SOCIAL SECURITY APPEALS AND CASE REVIEW PROCESS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

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SOCIAL SECURITY APPEALS AND CASE REVIEW PROCESS

FRIDAY, OCTOBER 23, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, D.C.

The subcommittee met at 10:15 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. J. J. Pickle (chairman of the subcommittee) presiding.

[Press release announcing the hearings follow:]

[Press Release of Friday, Oct. 9, 1981]

THE HONORABLE J. J. PICKLE (D-TEXAS), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY OF THE COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCED TODAY A HEARING ON THE SOCIAL SECURITY APPEALS AND CASE REVIEW PROCESS

The Honorable J. J. Pickle (D-Texas), Chairman of the Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold hearings on October 23 and 28, 1981 concerning the Social Security appeals and case review process and administrative structures. These hearings will be held on Friday, October 23, in the Main Committee Hearing Room, 1100 Longworth House Office Building, and Wednesday, October 28, in H-137 of the Capitol, both beginning at 10:00 a.m.

Chairman Pickle noted that once again the backlog of Social Security hearings is reaching crisis proportions and that this is an appropriate time to examine this problem along with other problems in a comprehensive review of the Social Security appeals and case review process. Illustrations of specific issues involved in the overall problem include:

(1) At the end of August there was a backlog of 128,551 hearing cases before the Office of Hearings and Appeals and it is estimated that this will grow to almost 200,000 in two years. The recent increase is due in large part to the decision of the Administration to accelerate the provision calling for the examination of the eligibility of persons on the disability rolls which would have been effective in January 1982 under the 1980 Disability Amendments.

(2) The apparent disparity in the adjudication of disability cases between the different administrative levels of adjudication and varying court interpretations of the law continues. The State agencies on reconsideration of the initial determination are affirming the denial of benefits in about 80 percent of the cases while the Administrative Law Judges (ALJs) are reversing about 60 percent of these State agency denials. An even higher percentage of the State agency terminations of benefits under the current examination of the eligibility of persons on the rolls are being reversed by the ALJs. The reasons for this situation will be explored at the hearings, and comments will be appreciated on pending proposals designed to promote uniformity in decision-making, specifically those in Title III of H.R. 3207, which has been adopted by the Social Security Subcommittee, and H.R. 3865 introduced by Chairman Pickle which would establish a Social Security Court.

(3) The ramifications of the applicability of the Administrative Procedures Act to the hearing process will be explored from both the standpoint of the quality of decision-making and the growing hearing workload. Mr. Pickle in the debate this week on the Department of Health and Human Services appropriations bill stated

that the Subcommittee would examine the problem of appointing additional hearing officers to meet the growing backlog of hearing requests and whether Administrative Procedures Act appointment procedures should be by-passed in doing this.

(4) The program of own-motion review of ALJs decisions (the Bellmon Amendment of the 1980 Disability Amendments) which is being implemented this month raises some controversial questions and falls within the scope of the hearing.

(5) Also the Administration's suggestion on pre-effectuation review which has just been submitted in a report required by the 1980 Conference Report will also be explored. The report recommends holding the percentage of State agency allowances which would be subject to the pre-effectuation review at 35 percent. Under the law the number of cases subject to review is scheduled to rise from 35 percent to 65 percent in fiscal year 1983 and thereafter.

(6) Finally, the attorney fee provision at both the administrative review and court level will be explored. There are allegations that the current method of setting fees is administratively burdensome and paternalistic. There are also questions of the compatability of the provisions passed last year in the Equal Access to Justice legislation (Public Law 96-581, effective October 1 of this year) with the fee provisions in the Social Security Act.

In addition other comments and suggestions relating to the Social Security appeals and case review process would be welcome. Invited Administration witnesses will testify at the hearing to be held on Friday, October 23. Other interested witnesses will be afforded an opportunity to testify at the hearing to be held on October 28.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony at the hearing should submit their requests to be heard by telephone to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515; telephone (202) 225-3627. The initial telephone request must be received by the Committee no later than noon, Thursday, October 22, 1981. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

Requests to be heard must contain the following information:

(1) The name, address, title, firm affiliation and/or organization the witness will represent (as well as a telephone number where he or his designated representative may be reached);

(2) If appearing in an individual capacity, a list of any clients at whose request or in whose employ the witness appears; and

(3) A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those filed for the written record of the hearing.

PROCEDURE TO BE FOLLOWED FOR SUBMITTING TESTIMONY

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Committee are required to submit 125 copies of their prepared statement to the full Committee office, Room 1102, Longworth House Office Building, at least 24 hours in advance of the hearing. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

For those who wish to file a written statement for the printed record of the hearing in lieu of a personal appearance, 5 copies are required and must be submitted to the Committee office by the close of business, Wednesday, November 11, 1982. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman **Pickle**. The subcommittee will come to order.

We are pleased to have special witnesses here this morning.

The Chair apologizes for being a bit late this morning, but we have a few preliminaries we had to attend to.

The hearing today will once again deal with the social security appeals process, an area of concern to this subcommittee and the Congress since the appeals crisis following the enactment of the SSI program in the mid-1970's. We are not yet at the workload crisis level but the estimates for the coming years are somewhat frightening. I promised the House on October 6 that we would look into this matter thoroughly and recommend appropriate action. The appointment of hearings officers apart from the Administrative Procedure Act, as proposed by the Appropriations Committee, is too big a step to take without a full examination of this complex and sensitive area.

We also are seeking comment on the provisions of our subcommittee bill [H.R. 3207] which are designed to encourage more uniform decisionmaking at the State agency and ALJ [administrative law judge] levels. Comments would also be appreciated on the bill I introduced to establish a social security court [H.R. 3865] which has a similar objective at the judicial level.

At this time I would like to introduce Mr. Louis B. Hays, Associate Commissioner for Hearings and Appeals, for his first appearance before our subcommittee. Mr. Hays is a career employee of the Social Security Administration who I am informed has the necessary energy and capacity to undertake this very difficult assignment. He had a distinguished reputation as the Director of the Office of Child Support. When asked why anyone would take a job like this, he said he likes challenges. He will undoubtedly find them in the Office of Hearings and Appeals. I know that he will respond with great competency and wisdom.

I am pleased now to receive testimony for the committee from you, Mr. Hays, and you may proceed.

STATEMENT OF LOUIS B. HAYS, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY PHILIP T. BROWN, CHIEF ADMINISTRATIVE LAW JUDGE; DANIEL L. SKOLER, DEPUTY ASSOCIATE COMMISSIONER FOR PROGRAMS; AND JOHN SNEE, PROGRAM INTEGRATION OFFICER, OFFICE OF ASSESSMENT

Mr. Hays. Thank you very much, Mr. Chairman, and I appreciate the opportunity to appear before your subcommittee to discuss the hearings and appeals process.

I am accompanied by Mr. Philip T. Brown, the Chief Administrative Law Judge; Mr. Daniel L. Skoler, the Deputy Associate Commissioner for Programs; and Mr. John Snee, Program Integration Officer, Office of Assessment.

Chairman Pickle. We are pleased to have all you gentlemen with us today.

Mr. Hays. I was appointed Associate Commissioner for Hearings and Appeals 3 months ago. In these past 3 months, I have devoted most of my time to identifying and analyzing the problems facing the Office of Hearings and Appeals, which as you know are severe and many, and initiating activities which I believe will resolve many of those problems. Today I would like to share with you some of my observations and plans.

First, I would like to say that I have had the opportunity to speak personally with over 100 of our administrative law judges [ALJ's]. As you know, the ALJ's are the people who make the Office of Hearings and Appeals work. I have been uniformly impressed with their dedication, professionalism, and sense of duty. I am confident that the administrative law judges are ready, willing, and able to respond to the challenges that I am about to discuss.

Let me begin by briefly discussing the SSA appeals process. An applicant for social security benefits who has been denied at the initial determination level may request, within 60 days of receipt of the notice, a review of the claim—referred to as reconsideration. An applicant who disagrees with the reconsideration determination may request, within 60 days of receipt of the notice, a hearing before an ALJ. The ALJ may decide the case on the record or hold a hearing during which the applicant and others may present oral testimony and evidence. An applicant who disagrees with the ALJ's decision may request, within 60 days, a review by the Appeals Council of the Office of Hearings and Appeals. A decision by the Appeals Council represents the final administrative decision and is made on behalf of the Secretary of Health and Human Services. A claimant dissatisfied with the final decision of the Secretary may file a civil action in the appropriate U.S. district court. The district court's decision is appealable to the appropriate U.S. circuit court, and the case may even end up in the U.S. Supreme Court.

I believe we are facing two major challenges in the hearings and appeals process. First, we expect a huge increase in our caseload this year and next. During fiscal year 1983, we estimate that the number of hearing filings will skyrocket to about 415,700, an increase of almost 50 percent over 1981's level. We expect that part of this projected increase will come from terminations of disability benefits resulting from SSA's continuing disability investigation initiative and the implementation of a provision in Public Law 96-265 [the Social Security Disability Amendments of 1980] which requires SSA to review the status of every nonpermanently disabled person at least once every 3 years. Other reasons for the anticipated rise in the caseload are the increased public awareness of social security in general, and the hearing process in particular, and more attorney involvement in the hearing process.

This expected increase comes at a time when we are already faced with a record high of over 128,500 cases pending before ALJ's. Our goal in fiscal year 1982 is to apply the management, operational, and procedural initiatives necessary to achieve the capacity to handle the current and rising caseloads.

The second major area requiring our immediate attention is the need to improve the quality and consistency of the decisional process. The most obvious indicator of the overall lack of consistency is the reversal rate at the hearing level. Lower level decisions for all categories of cases are now being reversed by ALJ's at a rate of 55.3 percent. The reversal rate for title II disability cases alone is now about 60 percent. We recognize, of course, that not all reversals are attributable to problems of quality and consistency. Some variance in a judgmental decisionmaking process must be expected, and there can be a progressive worsening of a claimant's medical condition during the course of the various reviews of the claim.

Nevertheless, there are clearly a significant number of reversals which occur simply because of differences in the approaches used by the Office of Hearings and Appeals, and by other SSA components and the States in making initial and reconsideration determinations. Our task is to fully understand the reasons for these differences in adjudicatory standards and then to work together to resolve the differences and achieve a more uniform application of the law and regulations at every level of the decisional process.

With regard to the rise in caseload, we are approaching the problem from two directions. First, we must increase the productivity of the staff carrying out the hearing process. At the same time, we must increase the size of our staff.

Large numbers of both ALJ's and support personnel are needed for the hearing offices. We will hire more than 100 additional ALJ's this year, expanding and maintaining the size of the corps to 800 members. Under current practices, of course, we only use OPM-certified ALJ's for hearing and deciding cases.

Attaining and maintaining an ALJ corps of 800 may be difficult to accomplish considering the problems we have experienced in the past in obtaining adequate numbers of qualified candidates. We are working with the Office of Personnel Management to secure the number of ALJ's we believe will be needed to handle the anticipated hearing workload.

We will also hire additional employees to fill support positions to raise the national level of support staff to ALJ's from its present level of 4.5 to 1 to 5 to 1. These additional employees will further permit ALJ's to devote their time almost exclusively to hearing and deciding cases.

Our workload problem, however, is not solvable by adding staff alone. It will also be necessary to greatly increase productivity. I think some historical background concerning our field staff's productivity will be useful to you. In the last 6 years, the number of ALJ's has increased by approximately 17 percent. During the same period of time, the number of dispositions per ALJ has doubled. In fiscal year 1975, the average ALJ disposition rate was 16 cases per month. During the first 11 months of fiscal year 1981, it was 32 per month. Even with an additional 100 ALJ's, we estimate that caseload increases will require an average disposition rate of about 45 cases a month per ALJ. Attaining this level of productivity will not be easy.

The key to further increasing our productivity is to insure fully efficient use of all our resources. As an example, I have seen persuasive evidence that significant increases in production can be achieved through the use of innovative workflow and organizational arrangements in hearing offices. In particular, these changes involve better utilization of support staffs and using different case development techniques. One of my goals during the next year will be to foster an attitude of willingness to experiment with innovative processing techniques throughout the field. We will work closely with the hearing office staffs to assist with their implementation of more efficient organizational arrangements and workflows.

We will also upgrade the quality of word processing equipment in the hearing offices. We intend to put more modern and efficient equipment in place during this fiscal year.

We also expect to improve the agency's performance through improved and expanded training programs for AJL's and their support staff. We will also provide management training for administrative law judges-in-charge of hearing offices and other hearing office management personnel.

We have a number of initiatives planned or underway to meet the challenge of improving decisional quality and consistency.

In response to section 304(g) of Public Law 96–265, the Bellmon amendment, we implemented an ongoing preeffectuation review of ALJ decisions favorable to claimants on October 1, 1981. This review is being carried out by a specialized unit of appeals analysts. Based on their recommendations, the Appeals Council will decide whether to excerise jurisdiction in these cases. The Appeals Council will reverse those ALJ decisions in which there is a clear error or abuse of discretion, or where the decision is not supported by substantial evidence. By the end of fiscal year 1982, we will be reviewing 15 percent of all ALJ reversals. I might mention that SSA is in the process of preparing the report on the Bellmon amendment review and will submit the report to the Congress by the due date of January 1, 1982.

We are working diligently with members of the ALJ corps and with other SSA components to identify and resolve the differences between OHA's and other components' interpretations of the law and regulations. We will also follow, by regulation, the same standards used by the State agencies in making initial and reconsideration determinations as contained in the SSA policy material known as the Program Operations Manual System, or POMS. I am confident that we will be successful in achieving much greater consistency at all adjudicative levels.

As I mentioned previously, we are strengthening our training for new ALJ's, and will place renewed emphasis on continuing education for all ALJ's. We believe that improved training of ALJ's can contribute significantly to the overall quality and consistency of decisions.

One OHA practice that has frequently been criticized is the use of a short form for fully favorable hearing decisions. I have ordered that this practice be halted and that AJL's provide a full rationale for decisions which reverse the State agency determinations, just as they do for affirmation decisions. This will eliminate the implicit incentive toward reversals that many critics felt was created by the use of the short form.

Finally, we intend to institute an experiment in several hearing offices using SSA representatives at those hearings in which the claimant is represented. This experiment was proposed several years ago but was not implemented. We believe that the participation of an SSA representative may enhance the objectivity of the ALJ's decision by improving record development and sharpening the issues. For these reasons, we plan to proceed with this experiment during this fiscal year.

Before I conclude my remarks, I would like to discuss, as you requested, the administration's plans for preeffectuation review of social security disability claims. The administration urges that this subcommittee favorably consider our recommendation to enact legislation to hold SSA's preeffectuation review of favorable disability determination to 35 percent in fiscal year 1983 rather than increasing it to 65 percent, as scheduled under present law. As you know, this recommendation was contained in a report to the Congress dated September 25, 1981, entitled "Preeffectuation Review of Social Security Disability Allowances."

Section 304(c) of Public Law 96-265 required SSA to review 15 percent of favorable initial disability decisions in 1981 and 35 percent in 1982. These preeffectuation review levels were clearly cost-effective in 1981 and are expected to be cost-effective in 1982, with minimum delays in benefit payments. However, it is not clear to us that the scheduled 65-percent review beginning in 1983 will be cost-effective, since it will require a significant increase in Federal and State staff to conduct these reviews, create a shortage of needed medical consultants, result in a decline in the proportion of erroneous allowances detected because the current level of review is targeted on the most error-prone cases, and result in delays in making benefit payments because of the significant workloads involved. We, therefore, recommend that the minimum review level be held at 35 percent until experience indicates that it should be changed. In the meantime, the improvements SSA is making in the adjudicative and appellate processes will reduce the potential for erroneous decisions.

In conclusion, Mr. Chairman, based on my review of the Office of Hearings and Appeals and my discussions with the regional chiefs, the ALJ's, the Policy Council, the ALJ Association, my executive staff, and others both within and outside of OHA, I am confident that the initiatives we have launched will enable us to meet the challenge of the escalating caseload and make marked improvements in the way we do business.

We welcome the review and suggestions of this subcommittee. We believe we have common goals—providing full due process of law to all claimants and protecting the interests of the taxpayers.

Mr. Chairman, that concludes my remarks. I would be pleased to answer any questions you or other members of the subcommittee may have.

Chairman PICKLE. Thank you. It is obvious that in the 3 months that you have been head of the OHA you have dedicated yourself to the task before you and the problems that we face.

The chairman recognizes Mr. Conable first for any observations he might have.

Mr. CONABLE. Well, Mr. Chairman, I thank you very much.

I would like to ask you, Mr. Hays, about the kind of growth of bureaucracy that accompanies the hearings and appeals process. It has been said, for instance, that the addition of office managers and other personnel to the field offices of administrative law judges resulted in further complicating procedures, not really in facilitating them. As any priesthood increases in size it becomes considerably less creative about religion but incredibly adept in ceremony, and I am wondering if you found that administrative law judges in any situation might be able to do their job more efficiently, accurately, and expeditiously if there were not a large supporting staff requiring the shuffling of a lot of papers? Would you comment on that.

Mr. HAYS. Sure; I share the concern that excessive layers of management and administration can get in the way of efficient and effective field operation. There is no question that over the last several years the number of so-called management positions as opposed to administrative law judges or the support staff who help them in their processing of hearing and deciding cases had increased.

I have no plans for making any further increases in the relative proportions of management staff to the true production staff.

However, one thing I have discovered is that, on the one hand, it is very true that, left to their own devices, so to speak, many of our hearing offices and individual administrative law judges have been able to come up with very innovative and creative ways of improving their performance and being able to hear and decide more cases without any deterioration in the quality of the service provided to our claimants.

Unfortunately what has happened is that we have had each of our 127 hearing offices around the country operating in a vacuum, and one hearing office or ALJ may come up with excellent ideas for improving the way in which they do business, but there has been no way in the past for other hearing offices to find out about these innovations, so we have had a situation of always having to recreate the wheel.

I have advertised for the services of an administrative law judge to come in from the field, someone who is very interested in improving and increasing efficiency and effectiveness, to head up a small and perhaps temporary staff in my immediate office devoted to hearing office innovation. This handful of people, headed up by an administrative law judge, would be able to go out and find out what is working well in our hearing offices and then disseminate and make this information available to the entire field and actually be available to go out to those hearing offices that would be interested in taking advantage of what some other hearing office has learned or developed and provide actual implementation assistance to those hearing offices.

So, I share your concern. I do not intend to let management interfere with the effective operations of the ALJ's.

I intend, in fact, to turn to them often and frequently as I have during the past 3 months for their ideas for how to get the job done, because I am convinced that those people who are closest to the problems, namely our ALJ's and their support staff in the field, are the people who have the best ideas for understanding and for solving those problems.

Mr. CONABLE. Thank you. I certainly did not mean to imply by my question any answer. I do notice that the tendencies of increasing professionalism sometimes involve hardening of the arteries, loss of flexibility, and a tendency to establish more and more complex rules when perhaps discretion would work just as well.

We wish you well in your work, sir. I think Members of Congress are particularly involved in appeals from constituents who feel themselves aggrieved by the process or feel themselves aggrieved by the delay in the process, and certainly anything that can be done to speed it up and to make it a more predictable process is going to be reflected up here in some reassurance by the administration and social security system as a whole.

Thank you.

Mr. HAYS. Thank you.

Chairman PICKLE. Mr. Hays, you have difficult problems in your agency, a continuing problem of making tough decisions but getting the right decision as much as possible, and you have to keep pushing for the decisions to keep up with the backlog.

I hope you end up being not any more unpopular, but you have a difficult job and so far have performed it well. I am confident you will commit yourself to this task because we have a backlog now of some 125,000 cases, and it may go up to 200,000. Obviously we have got to see the problem ahead of us.

Now, I want to ask you some questions on your testimony. First, I want to ask you a question relating to the Administrative Procedure Act. We have had two proposals basically presented to us in this committee, or through the Appropriations Committee, to allow for additional persons to hold these hearings. One suggestion would be through the process of qualified individuals to conduct hearings bypassing the regular Administrative Procedure Act, and the other way would be to do what was suggested by the Government in the *Blankenship* case which would be to use staff attorneys to conduct hearings.

Now, during the appropriations bill consideration a request was made to that committee to allow the SSA Administrator to employ individuals who would not have to comply with the civil sevice procedure as fully qualified ALJ's, but could do this task.

I notice in your testimony you have not recommended that procedure. Why did you not? Or do you recommend it?

Mr. HAYS. Mr. Chairman, as I mentioned in my testimony we are hoping to increase the size of the corps of ALJ's to approximately 800 individuals. That will require, because of the attrition rate—due to judges who retire or resign—hiring approximately 140 administrative law judges during the next 12-month period.

Based on what we now see coming to us from the Office of Personnel Management, it would not appear necessary at this time to consider going beyond the normal process of obtaining the services of fully qualified ALJ's.

For example, we are bringing on a class of 41 administrative law judges in early November.

Based on the available candidates, it appears as though we will have success in hiring additional numbers during the year. I must admit to you in all candor, however, that I still have some concern as to whether, when we get to the point of trying to hire our 100th, or our 120th, or our 140th ALJ over the next year, we will still be able to get qualified candidates from the OPM register. I do not mean just qualified candidates per se, but rather people who are willing to go to the locations where we have the need for administrative law judges.

Chairman PICKLE. Mr. Hays, I hope that you can meet your goal. I am a little disturbed here though as to why a short time ago the administration would request through the Appropriations Committee the right to hire a number of people bypassing the Administrative Procedures Act, and this morning you come and do not recommend that. Has there been a change of policy by the SSA or with your office on this?

Mr. HAYS. The testimony, my statement represents our policy.

Chairman PICKLE. But is it your policy or the SSA policy?

Mr. HAYS. Both. It is the administration's policy. We do not feel that it is necessary——

Chairman PICKLE. Are you saying that the administration does not now request the employment of other individuals unless they can qualify as regular ALJ's?

Mr. HAYS. That is correct.

Chairman PICKLE. I assume then that our decision was correct in opposing this provision because we felt that there ought to be a request from the SSA if they wanted to hire these people and bypass the APA. You do not wish to go that route.

Now, the next question I want to ask you is this. You think you are going to get 100 more ALJ's. But you have had difficulty doing this in the past. Where and how are you going to get 100 additional ALJ's which would necessitate you getting 140. The question is, can you get that many? Is it not doubtful that you would be able to hire that many?

Mr. HAYS. My understanding, Mr. Chairman, is that in the past several years it would have been extremely difficult to have obtained that many ALJ's.

However, our current experience in working with OPM suggests that we have a very good possibility of being able to hire that many ALJ's. As the economy has changed, more people want to become ALJ's, and more people seem to be willing to go to geographic locations which have not been considered highly desirable in the past.

Chairman PICKLE. Has the OPM indicated to you that they could supply you with 140 ALJ's?

Mr. HAYS. I am not sure that we have quite that firm a commitment. I am not sure that it is possible for OPM to make quite that firm a commitment.

Chairman PICKLE. What are you going to do if you do not get these extra people? You have got to have some extra people do you not?

Mr. HAYS. Yes, sir.

Chairman PICKLE. Suppose you do not meet that goal? Are you going to reserve judgment to that time?

Mr. HAYS. I suppose that if we suddenly later in the year discover that it is going to be impossible to come close to our goal, hiring that many ALJ's, that we might be in a position to come back to Congress and ask for some sort of emergency authority.

Chairman PICKLE. I have a feeling, and this is a personal feeling sitting here, that you hope that you will be able to hire 100 to 140, but you have some doubt that you will be able to do so. But you are going to do your best before you do anything else?

Mr. HAYS. That is essentially correct, Mr. Chairman.

Chairman PICKLE. It may be, Mr. Hays, that we have to have more assurance than just hope. We know for a fact that our backlog is going to go from 125,000 up to 200,000, and knowing that the avalanche is coming, we have got to have more plans than just hopes. So we would like for you to keep this committee advised regularly about the progress you are making in hiring these ALJ's.

Mr. HAYS. I did not mean to mislead you, Mr. Chairman. I think my position is somewhat stronger than mere hope. The problem is providing a guarantee that, in fact, those people will be there, but it looks very good at this point.

Chairman PICKLE. I notice in your remarks that you commented that the ALJ's are expected to have more productivity. That is desirable and I think they have already been getting more productivity. At least the production has gone from 16 a month in 1975 up to about 33 today. Now that is a doubling of their productivity. That is a good record.

Now you say that you hope that it's going to go up until they get 45 cases a month. Now the question is, can they actually do that? Can you expect that of them? Do you believe that they should be able to produce that?

Mr. HAYS. Yes, I do, Mr. Chairman. My belief is not based on something that I pulled out of the air. My belief is based on what the ALJ's themselves have told me. Over the last couple of months I have been involved in extensive discussions with many ALJ's and with all of our regional chief ALJ's, and they have told me essentially that if we are able to provide the additional support staff that we believe we can, if we upgrade the quality of our word processing equipment, and if we can provide additional training both to the ALJ's and the support staff, they feel themselves that 45 cases per month is a very achievable goal. In fact, I have had many ALJ's tell me that they think that 50 cases a month would be attainable, but frankly, at this point, I think I would be satisfied with 45.

Chairman PICKLE. If you have talked to many of the ALJ's yourself and they have indicated to you that they can attain this goal, then there is an agreement within the ranks that it is possible, and therefore you do not have any objection from them as a group as to this goal. That is encouraging.

I am going to recognize you in a minute, Mr. Shannon, but I have a couple more questions.

I notice that you want to reduce the preeffectuation review percentages to stop at 35 percent. Will you have completed the first phase of it and have completed 15 percent of preefectuation by January 1982?

Mr. HAYS. Mr. Chairman, I would like to refer that question to Mr. John Snee from SSA's Office of Assessment, who is prepared to address those kinds of questions.

Chairman PICKLE. All right, Mr. Snee.

Mr. SNEE. Mr. Chairman, we did send a report to Congress and to your subcommittee on preeffectuation review in the last fiscal year. We have found that preeffectuation review is very cost effective at the 15-percent level. As we move to fiscal year 1982, we are increasing that level from 15 percent to 35 percent as required by law. We expect that preeffectuation review will be cost effective in fiscal year 1982 partly because we are targeting the cases selected for review based on our quality assurance data, and on our preeffectuation experience in the past year.

We would expect, for example, that the 35 percent of the cases that we review will contain about 65 percent of all the erroneous favorable decisions made by the State agencies.

Chairman PICKLE. Now, you are saying that it is cost effective for a 15-percent review for the 1981 year; it will be cost effective to achieve a 35-percent level in 1982, but that it would not be cost effective to go beyond that figure.

Just for the record, why would it not be cost effective to go from the 35 to the 65 which Congress had passed in the 1980 act?

Mr. **Snee**. Well, Mr. Pickle, we are not sure that it will or will not be cost effective. What we do know is that we will have to double our staff from about 470 currently to about 980, and those 500 additional people will not be experienced people; they will take a great deal of training, and it will take a very long time for the people to become effective disability examiners. We are not sure that by increasing our staff by 500 to look at another 130,000 cases we are going to find the errors that are in those cases. We also think that we are putting a terrible strain on the medical resources available to SSA. We are not sure, for example, that we will have sufficient medical specialists available to us to examine the cases along with the disability examiners.

Chairman **Pickle**. Would it not be reasonable to say then that you already are complying with the goal of the 15-percent review, you are going to next year achieve the 35-percent level; at some time during the coming year you report back to this committee your appraisal of the cost effectiveness of the program at that 35-percent level before you ask us to make a change in the law and to freeze it at 35 instead of 65? If we go along in the next year and we find that we are doing well and that we could handle it, then I would think we would maintain the 65-percent level. I am not trying to reach that level just because I want to review every case that comes along.

Mr. **Snee**. No; that is not at all unreasonable. The problem is that we would have to increase our staffs, starting in the spring of next year, the current fiscal year, by large numbers of people in order to go to 65 percent.

Chairman **Pickle**. You are already having to increase your staff because of the normal workload. Cases are coming up by virtue of increased SSA appeals, disability insurance appeals, and even some appeals, through SSI. The caseload is still increasing, but it will double, I presume, by virtue of the fact that if we pass the 1980 law we must have a 3-year review of persons on the rolls.

Now the administration has sent out notices for these people to come in in advance of the time required by law, have you not?

Mr. **Snee**. If my understanding of the question is correct, what we have done in the last fiscal year and the current fiscal year is make changes in our regular processes so we do not have to hire large numbers of staff. We are essentially carrying out this process, in the past fiscal year, and the current fiscal year, with experienced personnel.

Chairman **Pickle**. Let us go back to it more specifically. It seems to me that the Reagan administration in their budget proposals and the Reconciliation Act has said that it would save approximately $200 million by accelerating periodic examination provision of the 1980 law. Now, some people had questioned this figure because they believe that a higher percentage would be reversed on appeal. So my question first would be to you, if that is your goal, what percentage reversal rate was assumed, and what is your experience to date?

Mr. SNEE. I assumed, Mr. Pickle, you were talking about preeffectuation review cases. The question concerns periodic review of people getting benefits.

Chairman PICKLE. I would want your rate on periodic review. I really want to think about what percentage you have with respect to the 3-year review of cases.

Mr. SNEE. I think if I recall the figures correctly, we are assuming that, of the periodic review cases that are reviewed in the next 2 fiscal years, we expect to have a termination rate of approximately 30 to 35 percent.

Chairman PICKLE. State that again for me, 30 to 35 percent?

Mr. SNEE. Yes, sir.

Chairman PICKLE. Would be what?

Mr. HAYS. That would be the percentage of cases which would be removed from the rolls as a result of the CDI initiative.

Chairman PICKLE. I have additional questions but before we go on I had better ask what is the reversal rate of that type of case?

Mr. HAYS. For budget purposes there is an estimate of what that reversal rate would be. I must admit that I do not recall that. I would be glad to supply it for the record. We do not yet know what the real reversal rate will be for those cases because we are not getting a lot of them into our system yet, and we do not yet have a system established to tack separately the reversal rates on CDI cases, but we will be developing the capability to report the reversal rate for those cases.

[Additional information follows:]

As the letter at p. 18 indicates, a 60-percent reversal rate at the hearing level was used for fiscal year 1982 and 1983 budgetary estimates.

Chairman PICKLE. Mr. Shannon.

Mr. SHANNON. Thank you, Mr. Chairman.

First of all, Mr. Hays, let me congratulate you on your testimony. It is very good and you have made a lot of progress in increasing the productivity in a very difficult area.

I would like to go back, if I could, to Mr. Pickle's initial question which has to do with this whole issue of whether or not non-ALJ hearing examiners should be hired and utilized.

I am not familiar with the background of how this got into the appropriations bill. Did the administration support it?

Mr. HAYS. It is my understanding that the administration did not take a position on that.

Mr. SHANNON. Did it oppose it?

Mr. HAYS. It did not oppose it or propose it.

Mr. SHANNON. And you have the same position, a nonposition, now as at that time? What I am asking, candidly, is if we were to try to propose the same thing, would you oppose it here?

Mr. HAYS. Well, as I was trying to explain before, given the way that the system works, the way that OPM obtains candidates for us, and based on our best indications, we think we have a very good shot at getting the number of people that we will need. We cannot guarantee it, because it is not within our control.

I think if we were to ask for anything at this point, it would be nothing more than some sort of an emergency standby authority which would not be invoked until such time as it proved to be impossible to hire regular ALJ's. We are not asking for that at this point. If the subcommittee chose to give it to us, I do not think we would oppose it.

Mr. **Shannon**. You obviously had no particular objections to the Appropriations Committee action?

Mr. **Hays**. Again, I view it in the same way. If it had been passed, it would have been virtually an emergency standby authority that we probably woud never have used, but it would be available.

Mr. **Shannon**. There has been no real change in your position then.

Let me ask you about this whole question of time limits. We have legislative proposals now which are pending in Congress to impose statutory limits at the State agency hearing levels. Do you think that the quality and fairness of decisionmaking would be affected by these proposals?

Mr. **Hays**. Well, I am not sure if the quality would be affected. I think it would probably be physically impossible to meet time limits given the size of the caseload, the increase in the caseload that we project, and our current staff levels.

Mr. **Shannon**. What would happen if you missed the time limit? Would you be held in contempt?

Mr. **Hays**. Under proposed legislation or under———

Mr. **Shannon**. Under either case, I guess.

Mr. **Hays**. Well, we are operating right now under a variety of court orders. We have over half a dozen court orders around the country that we are operating under in three States, I guess it is actually six separate court orders. We are required if we miss the time limit to actually make interim benefit payments to those claimants until such time as we issue a final decision.

Mr. **Shannon**. Have you been ordered to pay these benefits?

Mr. **Hays**. In a very few number of cases we have not been able, in spite of all of the things that we do, to meet the court ordered deadline.

For example, in the month of August, we ended up paying in about 42 cases in those 3 States in which we are under court order.

Mr. **Shannon**. A total of 42. That is a pretty good record.

Mr. **Hays**. Well, it is only done at the expense of enormous administrative burden on us and, I think, perhaps some detriment to those claimants who are not covered by court order, because we have to pull out all of the stops to give faster service to the court-order cases, which means those people who are not under court order do not get the same level of service.

Mr. **Shannon**. Well, Mr. Conable prefaced one of his questions by saying that he did not ask the question by means of criticism. I suppose Members of the Congress hear from more people on social security than any other area, and oftentimes there are complaints, but given that I must say that I think that the Social Security Administration is the better one of all Government agencies and I want to commend you for your work.

Mr. **Hays**. Thank you very much.

Chairman **Pickle**. Mr. Bailey, you are still considered a good member of this committee, and I appreciate your continued interest.

Mr. **Bailey**. Thank you, Mr. Chairman.

Your social security assessment office says that according to the staff work that you have done that there is a 97-percent accuracy rate on the reconsideration of the State agency assessment.

When they go to the administrative law judges it is stated there is a 60-percent reversal. Does this mean that perhaps something needs to be done with the assessment office?

Mr. HAYS. Those data which you have just mentioned have been of concern to us and the major impetus behind our goal of dramatically improving the quality of the decisionmaking process and consistency.

We are concerned by the fact that it is fairly clear from the data that you refer to, as well as other studies that have been done, that there are essentially two different approaches being taken right now.

Mr. BAILEY. That is what I am after. What are the reasons?

Mr. HAYS. One of my two major goals during this year is to first identify the differences in approach, primarily differences in the way in which the statute and the regulations are interpreted in the hearings and appeals process on the one hand, and by the State DDS's and the other SSA components on the other hand, and to understand and eliminate those differences.

Now, we are going about that in a variety of ways. We are working very closely with the people in Baltimore who direct the activities in State DDS's.

Mr. BAILEY. Have you ever done a breakdown on a State-by-State basis? Is that indicated anywhere?

Mr. HAYS. A breakdown in what sense?

Mr. BAILEY. Well, in terms of these disallowances? Have you had problems with certain States or certain regions? You mentioned in your remarks the different areas.

Mr. HAYS. Well, if I understand the quality assurance process correctly that is done through the Office of Assessment, the numbers and the accuracy rates are available for each separate State in the country, and they do vary somewhat.

Similarly, our reversal rates, which give some evidence of the discrepancy in the two processes, also vary from hearing office to hearing office. I am not sure if there is any way of putting the two together and seeing if you can point to individual States where there is a greater discrepancy between the OHA part of the process and the State part of the process. Perhaps Mr. Snee would like to speak to that.

Mr. BAILEY. Have you ever looked at the type of providers to see if there is a correlation there between disallowances and that type of thing? That is really what I want to address.

Mr. HAYS. Within the OHA world, so to speak, we have nothing on that. I do not know whether there is anything in the Office of Assessment. I would be doubtful if there was any correlation that can be demonstrated.

Mr. BAILEY. I did not know if you had ever looked at it or not, or if you even had a way of separating the data.

Mr. SNEE. Yes, sir; to the extent we have looked at it, there does not seem to be any distinction between the volume providers and the nonvolume providers.

Mr. BAILEY. There does not seem to be?

Mr. SNEE. There does not seem to be.

Mr. BAILEY. Thank you.

Chairman PICKLE. Again, Mr. Bailey, we are glad to have you with us. We appreciate your interest.

I wanted to ask a few other questions.

When an individual comes in and makes application at the State agency, at that level approximately 80 percent of these cases are denied, as I understand your figure; is that correct?

Mr. HAYS. Well, my figures, Mr. Chairman, show that, in fiscal year 1980, it was in fact, 70.8 percent.

Chairman PICKLE. Those are the latest figures. I knew it was a very high percent. Those cases have gone up to the State agency on reconsideration and if they are appealed; then you tell me that 60 percent of the cases that are appealed are reversed by the ALJ; is that correct?

Mr. HAYS. The 60-percent figure represents disability cases; the across-the-board reversal rate is running about 55 percent.

Chairman PICKLE. Fifty-five percent overall; with respect to the title II area it is 60. Now, it seems to me that is a very high percentage. They have been denied at the first level, and on appeal 60 percent are reversed. Is that a high level? Is that satisfactory to you? Is that normal? is that what we should expect?

Mr. HAYS. I think it raises some very serious questions, Mr. Chairman, as to the quality and the correctness of the decisions.

Chairman PICKLE. Which one? On the ALJ's part, or the State agency's part?

Mr. HAYS. Well, I think both, but within my most immediate area of interest it certainly raises questions about the correctness of the ALJ decisions.

I am not concerned about the reversal rate of the ALJ's in and of itself. What I am concerned about is that we make the correct decision.

Chairman PICKLE. But the reversal rate is a measurement of correctness?

Mr. HAYS. I certainly agree.

Chairman PICKLE. Mr. Snee's testimony said that the assessment office states that there is a 97-percent accuracy rate on State reconsideration decisions. Is that figure still applicable, that declining rate?

Mr. SNEE. That figure is approximately correct.

Chairman PICKLE. Would you submit to this committee your latest figure of the accuracy rate? If it is not 97 percent, what is it? We would like to know that.

Mr. SNEE. We will be glad to.

[The information follows:]

ACCURACY OF RECONSIDERATION DECISIONS

For the 9-month period ending September 30, 1981, SSA's quality assurance data show that State agency reconsideration decisions on Social Security and concurrent Social Security and Supplemental Security Income disability cases are 97.5 percent accurate—92.1 percent for reversals and 98.3 percent for affirmations. Although these accuracy rates are statistically valid, the sample of cases may be skewed since a number of affirmation cases selected for quality assurance review are not reviewed because many of the denied claimants file for a hearing before an Administrative Law Judge. The fact that these affirmation cases are not included in the quality assurance review may impact on the accuracy rate.

Pre-effectuation review experience show lower accuracy rates for reconsideration cases than does the quality assurance data. These accuracy rates are more reliable because the sample is much larger and because the sample is not skewed because of the hearing process. The overall reconsideration accuracy rate based on pre-effectuation review experience is 94.8 percent—91.1 percent for reversals and 96.2 percent for affirmations. The differences between accuracy rates as determined by the quality assurance and pre-effectuation reviews are statistically significant but are probably accounted for by the sample size and the validity of the samples per se.

The disparity between highly accurate reconsideration determinations, as measured by SSA's quality assurance and the pre-effectuation review processes, and a high reversal rate at hearings has been questioned previously by congressisonal committees. SSA is currently tabulating data from a review of hearing decisions, i.e., the Bellmon review, and will be providing Congress a report on the results of this review before the end of the year. The report will examine a number of potential causes for ALJ reversals, e.g., the effect of personal appearances of claimants at hearings and new medical evidence on ALJ decisions.

Chairman PICKLE. I do notice that either you or Mr. Hays, whichever division actually handles it, indicated the program of own-motion review of ALJ allowances would be effective on October 1. Who are you reviewing at this point, the high reversers, or is it just a random mix? Who and how do you determine who you will review?

Mr. HAYS. We are currently targeting our review on the high reversal ALJ's and hearing offices. We, as a way of starting this off, thought the most productive use of our resources would be to target on the high reversals, and we are looking at the 7 hearing offices which represent the highest reversing hearing offices in the country, and in those 7 hearing offices there are 31 ALJ's.

We are also looking at 35 individual administrative law judges from around the country who have the highest reversal rates in the country.

Chairman PICKLE. What reasons are there for this? Would that be helpful for me to know?

Mr. HAYS. There does not seem to be a geographic pattern, Mr. Chairman. It is spread around the country. Now, as of today, we are reviewing approximately 7½ percent of all reversal cases. Later in the year, as we add additional staff, we will be doubling that, then we will be able to look at additional ALJ's, and I hope at that time to be able to add a small random sample of cases so that we will, in effect, be reviewing all of our ALJ's, not just the high reversers.

Chairman PICKLE. Now, Mr. Bailey, I believe asked you a question regarding the time limit problem.

I notice that some of our colleagues in the Congress have introduced legislation to deal with the awkward delay in getting social security disability. They implied that cases would go on for months and months and even years before they would get a determination. I do not have reference to anyone in particular, but these bills are being circulated now in the Congress. We are going to hear more of this because the Members of Congress are concerned when they talk to an individual who says, "I made an application for disability, that was 2 years ago or 1 year ago, and I have not gotten any determination, I cannot work and I am disabled and I am just bogged down."

Is there validity to the accusation that there are unfair delays and the procedure is cumbersome? Has the system broken down, or are we proceeding at a normal, reasonable pace?

Mr. HAYS. I certainly do not feel that the system has broken down. I am not satisfied, however, with the level of service that we are providing to our claimants. I would say, however, that given the large number of cases that we receive each and every month and the level of staff that we have to handle those cases that we are doing an admirable job in responding to the appeals that are filed.

Chairman PICKLE. I would like you to submit to our committee a general statement in answer to these kind of assertions and claims. I will submit to you some of the letters that we have received in our offices so that we might know how to respond to them. I am not passing judgment, but I know that when this type of apprehension becomes a sort of crusade a lot of people feel very deeply that the process has broken down. Would you give us a statement on that, please?

Mr. HAYS. I would be pleased to.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., November 2, 1981.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security,
Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: At the October 23, 1981 hearing on Social Security Appeals and Case Review Process you asked me to provide your Subcommittee with a response to the assertion that the Hearings and Appeals process has "broken down" and that statutory time limits for case processing are desirable.

I assure you that the process has not broken down. During fiscal year 1981 we disposed of over a quarter of a million hearing requests with an average processing time of approximately 5½ months. The average processing time for fiscal year 1981 was only about 6 days longer than for fiscal year 1980. The average processing time peaked in fiscal year 1976 at over 9 months, dropped to a low of about 4 months in fiscal year 1978, and has been climbing slowly as the backlog of hearing requests grows.

We all would agree that improvement in our processing time is desirable. However, when faced with projections of a 50 percent increase in hearing requests, it is not realistic to expect a meaningful reduction in processing time in the short term. I am working to insure that OHA has the capacity to handle future workloads and at least maintain the current processing time. If OHA is successful in obtaining the additional resources it requires, and if productivity improves in line with my expectations, by the end of fiscal year 1983 our pending caseload will drop to the point where processing delays due to backlog are minimal.

Statutorily imposed time limits cannot be expected to result in significant improvements in processing time. OHA is already committed to providing hearings as expeditiously as possible. There is no way for the Department to comply with unrealistically short time frames. Huge increases in staff would be necessary at a time when we are already greatly expanding our workforce to merely keep abreast of the rising caseload.

Even without delay attributable to backlog, the hearing process is, of necessity, complex and highly individualized, and therefore time-consuming. Before a proper decision can be made, our staff must spend time reviewing the claim, obtaining needed evidence, scheduling the hearings etc. Often, there are the delays requested by the claimant, for example, to obtain counsel or additional evidence. We are concerned that forcing a decision to meet an artificially low time frame might deprive the claimant of the thorough and complete hearing and sound decision to which he is entitled, and subject the entire process to legal challenge as a denial of due process of law.

At the hearing I indicated I would supply for the record our fiscal year 1982 and fiscal year 1983 budgetary estimates of the reversal rate in continuing disability investigation cases at the hearing level. The estimated reversal rate is 60 percent for both fiscal years. The estimates were based on current reversal rates.

I hope this information is helpful to you. If I can be of further assistance, please let me know.

Sincerely yours,

LOUIS B. HAYS,
Associate Commissioner,
Office of Hearings and Appeals.

Chairman **PICKLE**. If we were to establish a time limitation, 30, 60, 120 days, two or three questions come to mind in connection with that. If the cases are automatically gotten out within a specified time frame, that increases the number of decisions, but would most of them be favorable or unfavorable?

Mr. **HAYS**. I do not know that there is any way of predicting that in advance. I would assume that, at least for the moment, the current rates between affirmations and reversals would stay essentially the same. There is certainly a risk, at least under the way that the system has worked in the past, that if you try to speed up the system in some artificial way that you will increase the reversal rate, and I do not think that would be a desirable result.

Chairman **PICKLE**. I have been told that if you push these decisions out that the decision is more likely to be favorable, and you are saying that there is some reason to believe that might be the pattern? You are now speaking with great authority, but that would probably be an opinion that you would have?

Mr. **HAYS**. Without some mechanisms to counter that effect, I think that would be the case.

Chairman **PICKLE**. Now, if we were to set a time limitation of 30, 90, 120 days, would this be a violation of due process? Do we have a constitutional question here? Would that be an argument?

Mr. **HAYS**. I suspect that that question would certainly be raised. If the only way that we could meet that time limit would be by not giving full consideration to the claimants and to develop the cases adequately, one could certainly argue that that could represent a violation of due process for the claimant.

Chairman **PICKLE**. I only have one or two other question, Mr. Hays. I note from your statistics that there seems to be a direct correlation between the ALJ productivity and the availability of staff support, and you are raising it from 4.5 per ALJ to 5 per ALJ. Are there increases provided for in the budget, and will we have any problem with hiring freezes?

Mr. **HAYS**. We hope, Mr. Chairman, to be able to work within the obvious constraints of the budget situation to get necessary authority through the Department and OMB to get the job done. For example, we were able to obtain an exception to the current freeze on hiring from outside the Department to bring on our first class of 41 administrative law judges.

Chairman **PICKLE**. On page 7 you said that next year one of your goals would be to foster an attitude of willingness to experiment with innovative processing techniques throughout the field. Has this been a problem in the past? Do you see any more willingness on the part of the ALJ corps to have a more open mind to this area?

Mr. **HAYS**. Yes, I do see such an indication of much more willingness to be openminded and to experiment. Quite frankly I think that there has been a serious problem within this organization in the past of the people at Arlington trying to dream up all of the solutions to the problems in the field and trying to mandate all of those solutions in the field without proper consultation in advance.

My philosophy is that we cannot ourselves direct change from above. We must seek change from below, and that is the way in which I am proceeding to work with this organization.

Chairman **Pickle**. In connection with that same thought you said on the same page, "The key to further increasing our productivity is to insure fully efficient use of all of our resources."

Now, you have about 400 staff attorneys at this time. Do you believe that you are effectively using this resource? A lot of attorneys, according to my staff, believe that they are in sort of dead end jobs. Do you feel that they are in dead end jobs? Are they being fully utilized?

Mr. **Hays**. Well, your question really has two separate answers. Yes, the staff attorneys are being well utilized. They are an essential and vital part of our ability to get out as many decisions as we are getting out today, and we think that we will need additional staff attorneys to boost our productivity. On the other hand, you are absolutely right when you point out that they are, in fact, in dead end jobs.

We have, as you pointed out, about 400 staff attorneys. Right now, for all practical purposes, they are stalled out at a certain level, and in spite of their obvious competence and the really excellent experience that they have gained in this process over the last several years, there is no available avenue right now for them to ever qualify to become full-fledged ALJ's at some point in the future. The only way they can do that is to leave the system, get some experience for a couple of years on the outside, and then try to qualify. But because they cannot put in the requisite year at the GS-14 level, there is no way under the current law and procedures that those folks will ever have an opportunity to become an ALJ, and I think that is a shame.

Chairman **Pickle**. Do you feel that they are being utilized at the present time with no prospects of their being able to be moved up to the ALJ level?

Mr. **Hays**. That is absolutely right.

Chairman **Pickle**. I want to go back to the original subject of the hearing to be sure that we understand each other. We were advised that the SSA wanted to hire many, many more individuals in substitution of the ALJ's and that this was requested of the Appropriations Committee. We deleted this provision from the appropriations bill because we had not received any requests from the SSA that they wanted to hire more people.

Now, I take it again, based on your testimony, that you are not asking for a deviation from our regular procedure, and that you expect to get at least 100 to 140 additional ALJ's from the OPM and you do not wish to go the route of adding people short of the regular civil service and the APA procedures; is that correct?

Mr. **Hays**. That is correct, Mr. Chairman.

Chairman **Pickle**. Now you also are in agreement that our caseload will probably go from 125,000 to approximately 200,000 by 1982?

Mr. HAYS. That is the pending caseload. The caseload in the sense of new cases coming in to us will rise from this year's level of about 280,000, about 50 percent, up to over 400,000 in 1983.

Chairman PICKLE. That is the hearing filings.

Mr. HAYS. Yes.

Chairman PICKLE. I am talking about the level from your present position.

Mr. HAYS. In terms of backlog and cases pending; yes.

Chairman PICKLE. So we have the prospect staring at us of at least 200,000 cases that will probably be before us in a backlog?

Mr. HAYS. That is if it is unchecked. The initiatives that I described earlier, Mr. Chairman, of boosting our productivity and increasing our staff will allow us to get that pending caseload under control, and by the end of fiscal year 1983, if we are able to carry out those initiatives, that backlog will be well under control.

Chairman PICKLE. What do you expect might be the 1983 backlog level if you get your people and you get this added productivity?

Mr. HAYS. I would say by the end of 1983 that our pending caseload would be back down to approximately 120,000 cases. While that sounds like a high number, in just looking at the bare number, you have to keep in mind that our process requires that we have a certain number of cases on hand to work. We need about 3 months' worth of work on hand for each ALJ to keep them fully occupied and keep the system productive. Once we get the caseload down to 120,000 cases pending, the true backlog would be very small.

Chairman PICKLE. If you had 45 a month productivity and you had 800 ALJ's that is 36,000 cases a month that you would be handling. Would that cut it down to 120,000?

Mr. HAYS. Yes.

Chairman PICKLE. Even if you have got that high level of productivity that is 200,000, and 36,000 off that, how do you get down to 120,000? How do you get that low?

Mr. HAYS. When you work out the arithmetic of what the pending caseload is today, what you expect in the way of additional receipts over this year, and what we project in disposition rate to do over the next 2 years.

Chairman PICKLE. But that would be 45 cases per month per ALJ or 36,000 dispositions a month; yes, that would make a difference. I can see that. Well, let us hope that you will be successful, and I do not think this committee intends to pass judgment, but we intend to hold you to what you said, and on that note we will conclude the hearings. I thank you for your testimony and for your presentation. We believe that you will stay with it, and we respectfully hope that you can.

Mr. HAYS. Thank you, Mr. Chairman, and I look forward to working with this subcommittee.

Chairman PICKLE. The Chair would like to add that this hearing will be continued this coming Wednesday. At that time we will have public witnesses on this same subject.

Mr. Hays, we will be glad to have you and your staff come and listen to the other side.

Mr. HAYS. Thank you.

[The following was subsequently received:]

DEPARTMENT OF HEALTH & HUMAN SERVICES Social Security Administration

Refer to: Baltimore MD 21235

December 17, 1981

Honorable J.J. Pickle
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are our responses to the supplemental questions from Members of the Social Security Subcommittee, as a follow-up to the October 23, 1981 hearing on the Social Security Appeals and Case Review Process.

I hope this information is useful to you. If I can be of any further assistance, please let me know.

Sincerely yours,

Louis B. Hays
Associate Commissioner
Office of Hearings and Appeals

Enclosure

Question (1) : Aren't there rather major differences in Court decisions which are reflected in ALJ decisions in the evaluation of pain, the need to call vocational experts, time limits on hearing cases, etc.?

Would our legislation in H.R. 3207 providing a statutory definition of pain help this situation? Should we consider even going further toward a Social Security Court which presumably would establish a more uniform body of precedent decisions?

Answer : We agree that differences exist in court decisions pertaining to some issues and the adjudication of those issues by administrative law judges (ALJ's). The differing interpretations by the courts do, of course, influence ALJ decisions. The following is a summary of the differing court interpretations on some of the major issues:

- Pain

Over the years several Circuit Courts have established rules that prohibit ALJ's from disregarding allegations of pain solely on the grounds that those allegations are not supported by objective medical findings. The effect of these rules is to require ALJ's to evaluate the complaints of pain on the basis of a variety of other factors, such as claimant's daily activities, medications, and credibility at the hearing. It appears that this rule is contrary, at least in spirit, to Regulation 404.1529, which requires that there be a medical condition which can be reasonably expected to produce pain of the degree alleged. That regulation is based on the current statutory definition of the term "disability" as a condition caused by "medically determinable" impairments.

Other courts are not nearly so demanding on this issue and will even accept implicit findings by ALJ's that the claimant's complaints of pain were not supported by such objective medical findings.

- Need for Vocational Expert Testimony

  Court decisions have varied widely on the question of the need for testimony of vocational experts at hearings. Some courts have found SSA's 1979 Medical/Vocational Guidelines Regulations invalid. Some courts have upheld the Regulations but have seriously questioned the agency's application of them, especially where questions of transferability of skills have been resolved without testimony by vocational experts. Some courts appear to have affirmed both the Regulations and their application without serious question. As could be expected, many of these decisions have been appealed and until these appeals are decided, we will not have anything approaching a uniform judicial view of the Medical/Vocational Guidelines.

- Time Limits for Holding Hearings

  In this area there has also been considerable variation among the courts. In several jurisdictions, ALJ's have been operating under time limits imposed by court orders in class action suits. These orders have been concentrated in certain geographical areas of the country, especially the Northeast. Most areas, however, have had no time limits imposed. Similarly, where cases are before the agency on remand from a court, some courts have habitually imposed the time limits on the agency's processing of individual cases. For example, the Middle District of Pennsylvania does so in nearly every court remand. These, again, are concentrated in certain geographical areas with large areas of the country untouched.

The Administration has not yet taken a formal position on the provision in H.R. 3207 that would provide a statutory definition of pain and the provision in H.R. 3865 to establish a Social Security Court. The language in H.R. 3207 providing the definition of pain is not significantly different from the language in the existing Regulations (404.1529 and 416.929). While conflicts among court decisions on the issue of pain might be resolved by a higher court ruling at some time in the future, a statutory definition of pain would also help clarify the situation.

As was noted by your Subcommittee in its discussion of a Social Security Court in March of this year, there are many far-reaching ramifications which have yet to be adequately explored. While it does seem very possible that a Social Security Court could result in improved uniformity of decisions at all levels, such a court's effectiveness in this regard would presumably be affected or determined by the specific charter and jurisdiction given to the court as well as its composition, size, organization, etc. Until these kinds of issues, as well as other sensitive matters such as selection and appointment of judges, costs, etc., are more fully explored, we believe it would be premature to take a position on the question of establishing such a court. Of course, full consideration of the question of a Social Security Court goes well beyond the competence of this agency.

Question (2) : Could you give us the results of the two phases of the National Pilot Study? I understand that we have been given some information on phase one--which was used to justify the program of accelerated CDI's.

Answer : The National Pilot Study of SSA's Disability Insurance (DI) program was performed in two phases. The purpose of the study was to test methods that SSA could use for performing an ongoing DI payment accuracy review, and to develop indications of the major types and causes of DI payment errors.

Phase I consisted of a review of about 3,000 cases randomly selected from the April 1979 DI payment rolls. Each case was subjected to a thorough examination of medical and non-medical factors affecting entitlement and payment, including beneficiary interviews and contacts with third party information sources. Briefly, findings from this phase of the study showed that:

- About 18 percent of the dollars paid in the sample went to beneficiaries who were found to be not disabled and therefore ineligible for the benefit.
- If projected to the universe of payments, the amount of excess payments (overpayments and payments to ineligibles) totaled about $2 billion per year.
- About 95 percent of the excess payments occurred because the beneficiary did not meet the medical entitlement factors.

(It should be noted that there are some constraints on the reliability of the 1-month study; however, it does provide a general indication as to the magnitude of the cost to the Trust Fund.)

Other SSA studies and a review by the General Accounting Office supported these findings and confirmed the existence of serious problems in the DI program, particularly in regard to SSA's actions in monitoring the disability rolls to verify that beneficiaries are still disabled. As a result of these studies, SSA has taken a number of steps to improve the continuing disability investigation (CDI) process under which certain cases are periodically reviewed to determine whether or not the beneficiary is still disabled.

One of the corrective action steps taken was to begin the triennial CDI process before the legislatively mandated date, i.e., accelerate the CDI program. As it was clear that failure to effectively monitor the DI caseload was resulting in a significant amount of misspent funds, and since the CDI process was proven to be effective in removing ineligibles from the benefit rolls, a decision was made to implement the triennial CDI review (mandated by P.L. 96-265) in March 1981, rather than wait for the required effective date of January 1982. In accelerating the effective date, we doubled the number of CDI's that were originally scheduled to be conducted in FY 1981.

In an effort to determine which cases deserved priority attention and should be reviewed in 1981, data from Phase I were analyzed to identify characteristics of cases with high payment errors. Using this screening technique, the early reviews were able to concentrate on those payments with the largest expected payoff in terms of reducing erroneous benefit payments. A full report detailing the Phase I findings is attached for your information.

You also asked about the results of Phase II. Data from the Phase II review are still being analyzed. A report on Phase II of the pilot study should be ready for release in early 1982. In Phase II of the study, a 3-month sample was reviewed and a greater proportion of cases received current consultative medical examinations and review by SSA medical staff. Other operational improvements in the review process were also made.

Attachment

Question (3) : (a) Would you please give us the statistics on average processing times at the State agency and ALJ's level for February 1981 and the latest month available? If this shows an increase, what is the reason for it?

(b) Would you also give us comparable figures on the number of cases pending 70 days and over?

(c) How many States have processing times in excess of the minimum prescribed period under the new State-Federal regulations? How many were over this time period in February 1981?

Answer : (a) The average processing times for initial cases by the State agencies for February 1981 and October 1981 are as follows:

	Title II	Title XVI
February 1981	46.8	55.5
October 1981	48.2	54.3

The increase in the DDS title II processing time is attributed to the:

- o Implementation of the personalized denial notices.
- o Increase in the continuing disability investigation caseloads.
- o Physician signature requirement on consultative examination reports.
- o Increased preeffectuation review activities.

The decrease in the title XVI processing time resulted from a systems modification in July 1981 which made the measurement comparable to that used in title II, i.e., mail time between the DO and DDS is not counted as DDS title XVI processing time. (Prior to July 1981, the DDS processing time included the mail time.)

The average processing time for hearings was 164 days in February 1981 and 169 days in October 1981. This increase reflects the steady rise in hearings receipts throughout fiscal year 1981, resulting in growing backlogs and longer average processing times. Receipts for the first quarter of fiscal year 1981 were 65,335 cases while during the last quarter of the year receipts rose to 73,886. Thus, despite an all-time high disposition rate of 32 cases per ALJ in 1981, the average hearing processing times grew throughout the year.

(b) The number and percentage of initial disability cases pending over 70 days were as follows:

	Title II	Title XVI
February 1981	10,848 (8.1%)	8,387 (8.1%)
October 1981	15,482 (11.1%)	11,283 (10.4%)

The increase in the number of cases pending over 70 days is attributed to the impact that the accelerated continuing disability investigation initiative has had on the State DDS's.

(c) The following States had processing times in excess of the threshold levels prescribed in the new State-Federal regulations (49.5 days for title II and 57.9 days for title XVI):

February 1981

Title II

- Alaska
- Colorado
- Delaware
- Illinois
- Indiana
- Kansas
- New Jersey
- New Mexico
- New York
- North Dakota
- Oklahoma
- Puerto Rico
- Rhode Island
- Texas
- West Virginia
- Wyoming

Title XVI

- Alabama
- Alaska
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Illinois
- Indiana
- Kansas
- Maryland
- Massachusetts
- New Jersey
- New Mexico
- New York
- North Dakota
- Pennsylvania
- Rhode Island
- Utah
- Vermont
- Washington
- West Virginia
- Wyoming

October 1981

Title II

- Rhode Island
- New Jersey
- New York
- Puerto Rico
- Delaware
- District of Columbia
- Maryland
- West Virginia
- North Carolina
- Tennessee
- Indiana
- Michigan
- Texas
- Colorado
- California

Title XVI

- Connecticut
- Rhode Island
- New Jersey
- Delaware
- District of Columbia
- Maryland
- Pennsylvania
- West Virginia
- Tennessee
- Indiana
- Colorado
- California

Question (4) : Within the last six months many State agencies have suggested that we defer the requirement for a personalized notice because of short lead-times and other workload requirements such as the accelerated continuing disability investigations. Does the Administration have any recommendation for our Subcommittee at the present as to this provision?

Answer : Preparing personalized denial notices does require substantial use of scarce State DDS resources and is time-consuming and costly. Also, pilot studies and preliminary experience in administering the provision do not show that personalized notices are accomplishing their intended objective. While the notices may give claimants a better understanding of why their disability claims were denied, it does not appear that they lessen the likelihood that claimants will appeal the decisions.

Elimination of the personalized denial notice requirement would alleviate the State DDS workload problems, but deferring the requirement would probably not ease these problems over the long run. The provision has been fully implemented by the States, and the resources needed to drop the personalized notice requirement and then to implement it again at a later date would probably result in little net relief to the State agencies. While we have no recommendations for changing the personalized notice provision at this time, we are considering whether any changes should be recommended.

Question (5) : Would you give us a brief summary of court cases prescribing time limits for disability cases? In how many jurisdictions, and to what extent, are interim benefits being paid?

Answer : At present, the Social Security Administration's Office of Hearings and Appeals is under court-ordered time limits in six States. These States and time limits are listed in the attached table. Each limit is subject to certain extensions and/or exceptions. In three of these States, the claimants receive court-ordered interim payments if the time limits are exceeded.

Interim payments are now being paid in only 34 cases and the number paid at any one time has always been small. However, the number has been kept low only by exceptional efforts to track and give faster service to court-ordered cases, which means that there are some delays in cases not under court order.

Attachment

STATUS OF TIME LIMIT COURT ORDERS

State	Order	Type of Claim	Time Limit	Interim Benefits	No. of Interim Benefit Cases Added, Oct. 1981	No. of Interim Benefit Cases Removed, Oct. 1981	Total Cases Receiving Interim Benefits, End of Oct. 1981
New York	Martinez	Disability: title II title II/XVI	120 days for decision	yes	7	10	13
New York	Sharpe	All title XVI: Non-disability title II/XVI	120 days to decision (disability) 90 days (non-disability)	yes	5	7	8
Connecticut	White	Disability title II title II/XVI	120 days to decision	yes	2	0	4
Connecticut	Lopez	Disability title II	120 days to decision	yes	0	6	9
Vermont	Barnett	Disability title XVI title II/XVI	90 days to hearing	yes	0	0	0
Vermont	Day	Disability Title II	180 days (from recon request to hearing)	yes	0	0	0
Massachusetts	Crosby	Disability title II title XVI	165 days to decision	No	N/A	N/A	N/A
Maine	Caswell	Disability title II title II/XVI	90 days to hearing	No	N/A	N/A	N/A
Kentucky	Blankenship	Disability title II title II/XVI	165 days to decision	No	N/A	N/A	N/A
						TOTAL:	34

Question (6) : We have had allegations that the current method of setting attorney fees is administratively burdensome and paternalistic. There are also questions of the compatibility of the provisions passed last year in the Equal Access to Justice Act legislation (Public Law 96-581, effective October 1, 1981) with the fee provisions in the Social Security Act.

Are there any Administration proposals contemplated in this area?

Answer : The involvement of personnel and other resources used to administer SSA's fee authorization and fee payment procedures has grown particularly burdensome in recent years. For example, less than 4,000 fee petitions were processed during 1970 but more than 59,000 fee petitions were processed during 1981. These petitions require individual evaluations and determinations by administrative law judges (ALJ's) and other high level personnel. Substantial costs are involved in administering these procedures. It is estimated that administration of the attorney fee provisions will cost SSA $5.2 million in FY 1982 and $7 million in FY 1983.

In addition, the present attorney fees process could be fairly characterized as a paternalistic interference by the Federal Government in the contractual relationship between claimants and their attorneys. Such matters are more appropriately left to private negotiations between individuals and their representatives.

The Administration is looking into whether SSA's involvement in approving and paying attorney's fees should be eliminated.

We are also concerned about the effect the Equal Access to Justice Act (EAJA), which went into effect on October 1, 1981, will have on the Social Security programs. The EAJA should not affect Social Security administrative appeals because they are not considered adversary proceedings. However, the application of the EAJA at the court level could raise some questions of compatibility because SSA has the authority to pay attorneys' fees from a person's past-due benefits and the Federal courts have the authority under the EAJA to pay the same attorneys' fees out of general revenues. Procedures will have to be worked out to prevent the duplicate payment of attorneys' fees in such situations. We are considering whether we should recommend the exemption of SSA-administered programs from the scope of the EAJA.

Overview: Disability Insurance National Pilot Study I

Since 1974, The Social Security Administration has been establishing quality review for all payment systems for programs administered by the Social Security Administration. The purpose of these reviews is to provide a measure of the accuracy of all payments made in the programs. Through a review of a sample of cases, the payment quality reviews provide a significant input in assessing the relative "health" of the program, its operating effectiveness and the quality of its underlying policies. The first payment quality system was developed for the Supplemental Security Income (SSI) program followed by a payment quality system for the Retirement and Survivors Insurance (RSI) program.

The Agency is now in the process of developing a payment quality system for the Disability Insurance (DI) program. The first step in the process involved a pilot review of 3,154 DI cases selected from the entire DI payment rolls for April 1979. Both the non-medical and medical aspects of the case were thoroughly reviewed to determine the accuracy of the payment received in the sample month.

The pilot test was originally designed to accomplish the following:

1. Implement on a trial basis, the DI Quality Review forms and procedures under actual operating conditions;

2. Obtain initial empirical evidence relative to several major quality review system design factors, and

3. Develop preliminary indications of the major types and causes of deficiencies in the DI program.

As a result of Phase I of the DI pilot, quality review operating procedures have been revised and the new procedures are being tested in Phase II which will produce data relative to July-September 1980. Additionally, the findings from Phase I are being used to develop preliminary corrective actions to improve the overall "health" of the DI program.

The findings from the pilot study showed that 18.2 percent of all dollars paid in the sample month were paid to beneficiaries who were determined by the review not to be entitled to benefits because they were not disabled. These findings also are in accord with the results of studies by the General Accounting Office and other studies by Social Security Administration.

The data from the pilot have been useful in implementing the provision in the 1980 disability admendments that requires that continuing disability in all DI cases be reviewed every 3 years, except for cases involving a permanent disability. SSA has in effect implemented this provision in April 1981 (rather than January 1982) by increasing the number of cases to be reviewed from 135,000 to 274,000 for FY 1981.

By using a "profile" system similar to the one developed for the SSI system, characteristics of the most error prone cases in the DI pilot were determined. The cases in the DI population with these characteristics were then targeted for review by SSA operational components in 1981. Concentrating on these high error cases will result in the largest amount of error reduction per case reviewed. In one group, as shown by DI pilot Phase I data, over 44 percent of the cases contained payment errors. The error cases in this group averaged in excess of $700 in payment error. Overall there were 20 groups identified by profile analysis of Phase I findings. Ten of these groups were subsequently used to identify cases to by reviewed by SSA operational components in 1981. These ten groups represent only 21 percent of the total DI caseload, but based on data from Phase I of the pilot test, they contain almost 50 percent of all error dollars in the DI program.

In addition, as a result of its own internal studies and an audit report by the General Accounting Office, SSA has taken a number of actions in the last 18 months to improve the continuing disability investigation (CDI) process under which certain disabled workers are periodically reviewed to determine whether they are still disabled. These actions include steps to assure that CDI's are conducted in all cases where they scheduled, to perfect automated systems support for the CDI process, and to assure that benefit payments are terminated promptly where beneficiaries are determined to be ineligible for continued benefit payments. Further, in 1980 SSA reallocated its resources to conduct many more CDI's than originally scheduled in order to remove more ineligible people from the Social Security disability and the SSI benefit rolls than would have otherwise occurred. This was accomplished through the following actions taken by the Agency.

- Budgeted in January 1980 to conduct an additional 130,000 CDI's in FY 1981, nearly doubling the number previously scheduled.

- Completed early in 1980 a review of over 10,000 persons who were converted from the State administered disability assistance rolls to the Federal SSI rolls in January 1974.

- Instituted a review (which will be completed in the near future) of 25,000 disability insurance beneficiaries who would not otherwise have been slated for a CDI.

The attached report provides, in detail, the findings from Phase I of the DI pilot study. The report is divided into four sections. The first section provides a detailed analysis of the pilot findings. This section includes not only discrepancy rates but also provides information on the types of payment deficiency found. The second section provides a detailed discussion on the error-prone profiles, a brief description of the system that was used to develop the profiles, and a copy of the actual profiles produced.* The third section provides error information based on the medical findings from the pilot study. The fourth section includes the findings from a reliability test performed to obtain information on the consistency of medical determinations.

There are several constraints, however, on the validity of the data derived from the pilot test. These constraints must be understood before the data can be used in proper context. First, the medically related deficiencies, by definition, require medical judgement. Previous tests conducted by agencies such as GAO have indicated that some degree of inconsistency exists due to the lack of objective measures for certain medical-vocational determinations. Second, this test represents the first time that the forms and procedures were used. Because of this, some definition and coding problems have occurred

*The discrepancy rates in Section I were arrived at after a case by case rereview was performed to correct coding errors in the original case findings. The deficiency information in Section I and the profiles in Section 2 were based on the original, uncorrected case findings. Because this data was derived before the final coding corrections were made, the deficiency information and the profiles do not relate exactly to the final discrepancy rate findings, but the impact is insignificant.

which do affect the results. Finally, the sample of cases was selected from DI payments made for only one month. Therefore, the data may not reflect the results which would be obtained over a longer period of time.

The Agency has undertaken a second phase of the DI pilot. This study differs from the first pilot study in several ways. Among these differences are:

1. A current consultative medical examination is being done on virtually all cases, as compared to less than half of the cases in Phase I.

2. Physician involvement is delayed until new medical evidence is available or until it is determined that no medical development is needed.

3. A second review of all cases will be completed by Central Office medical staff. In the first phase, only 40 percent of the cases received a second review. This review was performed by a regional medical staff.

4. The sample is drawn from the DI benefit rolls for July, August, and September 1980, not just a single month as in the first phase.

The results from Phase II of the DI pilot study will be available in the third quarter of calendar year 1981.

ATTACHMENT 1

Preliminary Disability Insurance Pilot I Findings

April 1979

I. General

The Disability Insurance (DI) Pilot Study I represents the first phase in the development of a quality review system for the DI program. Once in operation, this quality review system will be able to measure the accuracy of all payments made in the DI program. In addition this system will provide detailed information on the types and causes of deficiencies contributing to the discrepancy rates. This information will serve as a basis for identifying corrective actions to improve payment accuracy. The DI quality review system will be the third such system developed by the Social Security Administration. Currently, quality review systems have been established for the Supplemental Security Income (SSI) program and the Retirement and Survivors Insurance (RSI) program.

The DI Pilot Study I was conducted in 1979 and 1980 and consisted of a review of 3,154 cases randomly selected from the entire universe of primary beneficiaries in current payment status for April 1979. Each case was subjected to a thorough review of all factors of entitlement and payment, including home visits and contacts with third party sources of information, to determine the accuracy of all payments made to the sampled case for the sample month. Where appropriate, a payment discrepancy was determined based on conditions and circumstances that existed during the sample month. In addition to reviewing and verifying all non-medical factors, current medical evidence was obtained and, if necessary, consultative examinations were purchased. In each case, a redetermination was made with respect to the beneficiary's disability status in the sample month, April 1979.

The original purpose of the DI Pilot Study was to:

- Implement on a first test basis the DI Quality Review forms and procedures under actual operating conditions;
- Obtain empirical evidence in relation to several major design factors, and
- Develop indications of the major types and causes of deficiencies in the DI benefit payments.

The validity of the data from this effort therefore, has several constraints which must be understood before the data can be used in proper context.

- The medically related deficiencies, by definition, require medical judgment; previous tests conducted by agencies such as GAO have indicated that some degree of inconsistency exists due to the lack of objective measures for certain medical-vocational determinations.
- The forms and procedures were used for the first time, and some definition and coding problems have occurred which have some effect on the results.
- The sample of cases was selected from DI payments made for only one month; therefore, the data may not reflect the results over a longer period of time.

Another, and perhaps more important, consideration to keep in mind when examining the results of the DI Pilot I data is that the judgments made in this pilot study as to nondisability do not mean that the individual so judged will be taken off the rolls. The true number of beneficiaries who will be removed from the rolls can only be found operationally after the beneficiaries, whose disabilities were judged questionable by the Pilot reviews, have exhausted all their appeal opportunities and are in fact taken off the rolls. The DI Pilot I has identified, as a minimum, a significant number of beneficiaries whose disabilities are questionable.

II. Overall Disability Payment and Case Discrepancy rates

A. Definitions

For Quality Review purposes, a discrepancy is defined as a payment difference existing between the amount of disability insurance benefits paid to all beneficiaries in a sampled case for the sample month and the amount the quality review process determines should have been paid to that case. Discrepancy rates are reported for both payment (dollar) errors and case errors.

The DI payment discrepancy rate is defined as the sum of sample dollars paid in error as a percentage of the sum of all DI sample dollars paid. For reporting purposes "in error" includes: overpayments of $5 or more and all payments to non-entitled individuals, regardless of the amount. Overpayments of any amount are recorded on the DI quality review data base.

The DI case discrepancy rate is defined as the number of sample cases with an excess payment as a percentage of the total number of sample cases. Cases with an excess payment error include: cases with overpayments of $5 or more and cases with a payment to non-entitled individuals, regardless of the amount.

In addition to the above, the quality review process collects data on cases in which a beneficiary was underpaid. For reporting purposes, an underpayment must be $5 or more, although underpayments of any amount are carried on the DI quality review data base. To prevent misunderstanding, underpayment case and payment discrepancy rates are reported separately.

DI discrepancy rates are also reported in terms of administrative or beneficiary responsibility for their existence. Administrative error is that portion of the erroneous payments which are subject to a high degree of control by the Social Security Administration (SSA) or which result from the failure of the administration to discharge its reponsibilities in a proper and timely manner. Beneficiary error is that portion of the erroneous payments which results from the failure of the beneficiary to fully and accurately report required information to SSA.

In addition, DI discrepancy rates are reported in terms of whether the payment discrepancy for the sampled case is due primarily to medical or non-medical entitlement factors.

B. Payment Discrepancy Rate - Excess Payments (Table I)

- Sample

Dollars Paid	-	$1,100,023
Excess payments	-	$ 210,684
Payment Discrepancy Rate	-	19.2%

- Population

Dollars paid	-	$974,638,938
Projected Excess Payments	-	$186,669,579

- Observations

  97.7% of the excess payments were payments to non-entitled beneficiaries.

  95.6% of the excess payments were due to medical entitlement factors.

69.0% of the excess payments were caused by factors under administrative control.

C. Case Discrepancy Rate - Excess Payments (Table II)

- Sample

  Cases - 3,154
  Excess payment cases - 640
  Case Discrepancy Rate - 20.3%

- Population

  Cases - 2,784,389
  Projected Excess Payment Cases - 565,000

- Observations

  90.5% of the excess payment cases contained discrepancies which resulted in payments to non-entitled beneficiaries.

  89.7% of the cases were in error due to medical factors.

  67.3% of the discrepancies were caused by factors under administrative control.

D. Underpayment Payment and Case Discrepancy Rates (Table III)

- Payment Discrepancy Rate

Sample payments	-	$1,100,023
Underpayments	-	$ 3,776
Payment Discrepancy Rate	-	0.34%
Underpayments projected to population	-	$3,349,195

- Case Discrepancy Rate

Sample cases	-	3,154
Underpayment cases	-	71
Case Discrepancy Rate	-	2.25%
Underpayment cases projected to population	-	62,679

- Observations

  All underpayment cases were due to non-medical entitlement factors.

  64.7% of the underpaid dollars and 85.8% of the underpaid cases were caused by factors under administrative control.

III. Deficiency Findings

A. Definitions

For corrective action purposes, information is gathered on deficiencies occurring in the sampled cases. A deficiency is defined as a characteristic of a sampled case which causes incorrect payment information to be recorded. A payment discrepancy finding will always be associated with one or more deficiencies. For purposes of corrective action analysis and planning, all deficiencies in a case are recorded, even though the total amount of deficiency dollars may exceed the total amount of discrepancy dollars. This is done because multiple deficiencies will occur independently of each other. Corrective action to remove one of two or more such deficiencies would be effective only for that one and thus would not result in correct payments being issued. For example, a student beneficiary is determined not to meet the relationship requirements necessary for entitlement. Also, he is determined not to be in full time attendence at a qualified educational institution. Either factor by itself results in ineligibility, and both must be dealt with before a payment discrepancy ceases to exist. By coding all deficiencies, the potential dollar impact of each can be determined. Because multiple deficiencies are recorded, there is no one-for-one correlation between reported discrepancy findings and reported deficiency findings. The total number of deficiencies found and the resulting deficiency payment error will generally exceed the number of discrepant cases and corresponding payment error. Nevertheless, using proportions, conclusions about the impact of specific deficiency types on the discrepancy rates can be made for corrective action purposes. Thus, it can be presumed that those deficiencies contributing the largest proportions of total deficiency excess dollars will also have the greatest effect on the discrepancy rates.

Besides reporting deficiency types and error amounts, additional attributes which further define the deficiency are recorded. They include, but are not limited to:

1. Deficiency Cause - Why the deficiency occurred.
2. Deficiency Location - The location in the SSA claims process and the organizational component where the deficiency occurred.
3. Method of Discovery - The point in the Quality Review process where the deficiency was first discovered.
4. Beneficiary Type - The Beneficiary Identification Code (BIC) of the beneficiary associated with the deficiency.

B. Major Deficiency Types

- Excess Payments (Table IV-1, IV-1a - IV-1e)

  Two deficiency types accounted for over 97% of the incorrect dollars resulting in excess payments:

  (1) Disability requirements not met (96.3%).

  (2) School attendance requirements not met (1.4%).

Detailed information on the five major deficiency types resulting in excess payments is shown on Table IV-1a - IV-1e.

- Underpayments (Tables IV-2, IV-2a - IV-2e)

  Three deficiency types accounted for over 92% of the incorrect dollars resulting in underpayments:

  (1) Workmen's Compensation Offset (65.1%).

  (2) Computation of benefit amount incorrect (16.1%).

  (3) Wages incorrect (11.4%).

  Detailed information on the five major deficiency types resulting in excess payments is shown on Tables IV-2a - IV-2e.

C. Major Deficiency Causes

- Excess Payments (Table V-1)

  The two major causes of excess payments accounted for over 63 percent of all excess payments:

  (1) Incorrect medical determination where no consultative examination was conducted to support the determination (33.3%).

  (2) Beneficiary failed to report information (30.0%).

  Administrative causes were responsible for 67.7% of the excess payments.

- Underpayments (Table V-2)

  Two major causes of underpayment deficiencies accounted for over 45% of the incorrect dollars:

  (1) Beneficiary failed to report information (26.0%).

  (2) Incorrect processing of manual action (19.2%).

  Administrative causes were responsible for 66.3% of the underpayment dollars.

D. Characteristics of Excess Payment Deficiencies

- The majority of the deficiency excess payments occurred due to administrative causes (67.7%). The two major administrative causes were Incorrect Medical Determination, CE not conducted (33.3 percent of all deficiency excess payments) and Incorrect Medical Determination based on Medical Factors (23.0 percent of all deficiency excess payments).

- The major beneficiary cause of excess payments was Failure to Report Information (30.0 percent of all deficiency excess payments).

- Most of the excess deficiency dollars occurred during the medical determination process—as part of the Medical Post-entitlement Process (36.6%) or the Initial Medical Determination Process (36.0%).

- The two locations where most of the excess payment dollars occurred were State Agencies (35.2%) and Beneficiary (31.3%).

- The two major methods of discovery were contacts through other sources, most probably medical records (65.2%), and SSA Records (29.0%).

- The bulk of the excess payments were made to the primary beneficiary (95.3%), the person on whose Social Security number payments are being made.

E. Characteristics of Underpayment Deficiencies

- Over 66.3 percent of underpayment dollars were due to administrative causes. The major administrative cause was Incorrect Processing of Manual Action (19.2 percent of all underpayment dollars).

- The major beneficiary cause of underpayments was Failure to Report Information (26.0 percent of all underpayment dollars).

- Most of the underpayment dollars occurred during the Non-medical Post-entitlement Process (74.8%).

- The two locations accounting for the majority of the underpayment dollars were the Payment Service Center including the Office of Disability Operations (46.1%) and Beneficiary (32.5%).

- The majority of the underpayment dollars were discovered through SSA Records (70.0%).

- The bulk of the underpayments were made to the primary beneficiary (70.3%).

TABLE I

DI PAYMENT DISCREPANCY RATES (EXCESS PAYMENTS)

APRIL 1979

	SAMPLE	POPULATION
TOTAL PAYMENTS	$1,100,023	$974,638,938
EXCESS PAYMENTS	$ 210,684	$186,669,579

PAYMENT DISCREPANCY RATE

	ADMINISTRATIVE			BENEFICIARY			TOTAL		
PAYMENT EFFECT	MEDICAL	NONMEDICAL	TOTAL	MEDICAL	NONMEDICAL	TOTAL	MEDICAL	NONMEDICAL	TOTAL
OVERPAYMENTS	0.1	0.1	0.2	less than 0.05	0.3	0.3	0.1	0.4	0.5
PAYMENTS TO NOT ENTITLED	12.9	0.1	13.0	5.3	0.4	5.7	18.2	0.5	18.7
TOTAL	13.0	0.2	13.2	5.3	0.7	6.0	18.3	0.9	19.2

TABLE II

DI CASE DISCREPANCY RATES (EXCESS PAYMENTS)

APRIL 1979

	SAMPLE	POPULATION
TOTAL CASES	3,154	2,784,389
EXCESS PAYMENT CASES	640	565,000

CASE DISCREPANCY RATE

PAYMENT EFFECT	ADMINISTRATIVE			BENEFICIARY			TOTAL		
	MEDICAL	NONMEDICAL	TOTAL	MEDICAL	NONMEDICAL	TOTAL	MEDICAL	NONMEDICAL	TOTAL
OVERPAYMENTS	0.3	0.8	1.1	0.1	0.7	0.8	0.4	1.5	1.9
PAYMENTS TO NOT ENTITLED	12.4	0.2	12.6	5.4	0.4	5.8	17.8	0.6	18.4
TOTAL	12.7	1.0	13.7	5.5	1.1	6.6	18.2	2.1	20.3

TABLE III

DI UNDERPAYMENT PAYMENT AND CASE DISCREPANCY RATES

APRIL 1979

PAYMENTS

	SAMPLE	POPULATION
TOTAL DOLLARS PAID	$1,100,023	$974,638,938
TOTAL DOLLARS UNDERPAID	$ 3,776	$ 3,349,195

PAYMENT DISCREPANCY RATES

	ADMINISTRATIVE	BENEFICIARY	TOTAL
MEDICAL	0.00	0.00	0.00
NON-MEDICAL	0.22	0.12	0.34
TOTAL	0.22	0.12	0.34

CASES

	SAMPLE	POPULATION
TOTAL CASES PAID	3,154	2,784,389
TOTAL CASES UNDERPAID	71	62,679

CASES DISCREPANCY RATES

	ADMINISTRATIVE	BENEFICIARY	TOTAL
MEDICAL	0.00	0.00	0.00
NON-MEDICAL	1.93	0.32	2.25
TOTAL	1.93	0.32	2.25

TABLE VI-1

MAJOR DEFICIENCY TYPES

OVERPAYMENTS AND PAYMENTS TO NOT ENTITLED

APRIL 1979

DEFICIENCY TYPE	PERCENT OF INCORRECT DOLLARS	PERCENT OF ALL DEFICIENCIES
DISABILITY NOT MET	96.26	88.31
SCHOOL ATTENDANCE REQUIREMENT NOT MET	1.38	2.68
DEATH OF BENEFICIARY	0.66	0.56
APPLICATION REQUIREMENT NOT MET	0.39	0.56
WORKMEN'S COMPENSATION OFFSET	0.34	0.85
COMPUTATION OF BENEFIT AMOUNT INCORRECT	0.19	2.25
CHILD-IN-CARE PROVISIONS NOT MET	0.17	0.42
WAGES INCORRECT	0.15	2.11
MARRIAGE REQUIREMENT NOT MET	0.12	0.42
CHILD DOES NOT MEET RELATIONSHIP REQUIREMENT	0.10	0.28

TABLE IV-1a

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Overpayment and Payment to Not Entitled

DEFICIENCY TYPE Disability Requirements Not Met

PROJECTED INCORRECT DOLLARS	165,115,859
PAYMENT ERROR RATE	16.94
PROJECTED INCORRECT CASES	553,523
CASE ERROR RATE	19.89

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Incorrect Medical Determination (No CE)	34.64
2. Beneficiary Failed to Report Information	29.62
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Medical Post-entitlement Process	37.81
2. Initial Medical Entitlement Determination Process	37.32
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. State Agency	36.53
2. Beneficiary	29.96
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. Other	67.75
2. SSA Records (MBR, SSR, SER, DO/BO, PSC, etc.)	28.86
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	97.32
2. Child (C)	2.23

TABLE IV-1b

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Overpayment and Payment to Not Entitled

DEFICIENCY TYPE School Attendance Requirements Not Met

PROJECTED INCORRECT DOLLARS	2,365,665
PAYMENT ERROR RATE	0.24
PROJECTED INCORRECT CASES	16,773
CASE ERROR RATE	0.60

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Beneficiary Failed to Report Information	80.48
2. Beneficiary Provided Incomplete or Incorrect Information	17.73
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Non-medical Post-entitlement Process	100.00
2.	
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. Beneficiary	98.21
2. Office of Systems	1.79
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. State/Local Government Public Records	54.76
2. Beneficiary	36.40
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Child (C)	100.00
2.	

TABLE IV-1c

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Overpayment and Payment to Not Entitled

DEFICIENCY TYPE Death of Beneficiary

PROJECTED INCORRECT DOLLARS	1,125,861
PAYMENT ERROR RATE	0.12
PROJECTED INCORRECT CASES	3,531
CASE ERROR RATE	0.13

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Third Party Failed to Report Information	61.85
2. No Action Taken on Third Party Report	19.82
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Non-medical Post-entitlement Process	72.20
2. Medical Post-entitlement Process	27.80
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. Beneficiary	80.18
2. District Office/Branch Office	19.82
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. Spouse or Other Relative in Household	47.61
2. State/Local Government Publich Records	34.05
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	100.00
2.	

TABLE IV-1d

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Overpayment and Payment to Not Entitled

DEFICIENCY TYPE Application Requirement Not Met

PROJECTED INCORRECT DOLLARS	660,614
PAYMENT ERROR RATE	0.07
PROJECTED INCORRECT CASES	3,531
CASE ERROR RATE	0.13

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Beneficiary Provided Incomplete or Incorrect Information	63.02
2. Incorrect Processing of Manual Action	25.17
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Initial Non-medical Entitlement Determination	74.83
2. Initial Medical Entitlement Determination Process	25.17
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. Beneficiary	63.02
2. PSC (Includes Office of Disability Operations)	25.17
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. Employer (Present or Past)	63.02
2. SSA Records (MBR, SSR, SER, DO/BO, PSC. etc.)	36.98
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	88.20
2. Young Wife (B2, B5)	11.80

TABLE IV-1e

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Overpayment and Payment to Not Entitled

DEFICIENCY TYPE Workmen's Compensation Offset

PROJECTED INCORRECT DOLLARS	576,265
PAYMENT ERROR RATE	0.06
PROJECTED INCORRECT CASES	5,296
CASE ERROR RATE	0.19

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. No Action Taken on Reported Post-entitlement Change	59.41
2. Beneficiary Failed to Report Information	21.31
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Non-medical Post-entitlement Process	85.99
2. Initial Non-medical Entitlement Determination	14.01
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. PSC (Includes Office of Disability Operations)	78.69
2. Beneficiary	21.31
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. SSA Records (MER, SSR, SER, DO/BO PSC, etc.)	78.69
2. Public Pension/Benefit Program	21.31
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	73.77
2. Child (C)	26.23

TABLE IV-2

MAJOR DEFICIENCY TYPES

UNDERPAYMENTS

APRIL 1979

DEFICIENCY TYPE	PERCENT OF INCORRECT DOLLARS	PERCENT OF ALL DEFICIENCIES
WORKMEN'S COMPENSATION OFFSET	65.07	32.48
COMPUTATION OF BENEFIT AMOUNT INCORRECT	16.06	31.62
WAGES INCORRECT	11.40	29.91
MISCELLANEOUS PAYMENT DEFICIENCY	4.85	1.71
AGE REQUIREMENT	1.64	2.56
SELF-EMPLOYMENT INCOME	0.52	0.86
DISABILITY PROVISIONS	0.46	0.86

TABLE IV-2a

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Underpayment

DEFICIENCY TYPE Workmen's Compensation Offset

PROJECTED INCORRECT DOLLARS	2,323,933
PAYMENT ERROR RATE	0.24
PROJECTED INCORRECT CASES	33,546
CASE ERROR RATE	1.20

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Beneficiary Failed to Report Information	39.59
2. Incorrect Processing of Manual Action	21.82
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Non-medical Post-entitlement Process	90.62
2. Initial Non-medical Entitlement Determination	9.38
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. PSC (Includes Office of Disability Operations)	51.18
2. Beneficiary	39.59
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. SSA Records (MBR, SSR, SER, DO/BO, PSC, etc.)	60.41
2. Public Pension/Benefit Program	35.60
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	70.71
2. Child (C)	20.79

TABLE IV-2b

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Underpayment

DEFICIENCY TYPE Incorrect Computation of Benefit Amount

PROJECTED INCORRECT DOLLARS	573,519
PAYMENT ERROR RATE	0.06
PROJECTED INCORRECT CASES	32,664
CASE ERROR RATE	1.17

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Incorrect Determination (Non-medical Factors)	32.38
2. Incorrect Processing of Manual Action	27.30
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Initial Non-medical Entitlement Determination	54.01
2. Non-medical Post-entitlement Process	45.99
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. PSC (Includes Office of Disability Operations)	48.32
2. District Office with PSC Review	27.11
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. SSA Records (MBR, SSR, SER, DO/BO, PSC, etc.)	99.18
2. Other	0.82
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	68.55
2. Child (C)	28.10

TABLE IV-2c

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Underpayment

DEFICIENCY TYPE Wages Incorrect

PROJECTED INCORRECT DOLLARS	407,213
PAYMENT ERROR RATE	0.04
PROJECTED INCORRECT CASES	30,898
CASE ERROR RATE	1.11

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Incomplete Development/Verification	43.21
2. Incorrect Determination (Non-medical Factors)	13.16
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Initial Non-medical Entitlement Determination	68.71
2. Non-medical Post-entitlement Process	31.29
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. PSC (Includes Office of Disability Operations)	44.43
2. District Office With PSC Review	17.01
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. SSA Records (MBR, SSR, SER, DO/BO, PSC, etc.)	84.88
2. Employer (Present or Past)	6.05
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	93.62
2. Child (C)	3.76

TABLE IV-2d

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Underpayment

DEFICIENCY TYPE Miscellaneous Payment Deficiency

PROJECTED INCORRECT DOLLARS	173,305
PAYMENT ERROR RATE	0.12
PROJECTED INCORRECT CASES	1,765
CASE ERROR RATE	0.06

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Beneficiary Provided Incomplete or Incorrect Information	88.45
2. Incorrect Data Transfer to System	11.55
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Non-medical Post-entitlement Process	100.00
2.	
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. Beneficiary	88.45
2. District Office/Branch Office	11.55
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. SSA Records (MBR, SSR, SER, DO/BO, PSC, etc.)	100.00
2.	
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Child (C)	100.00
2.	

TABLE IV-2e

DEFICIENCY ANALYSIS

APRIL 1979

PAYMENT EFFECT Underpayment

DEFICIENCY TYPE Age Requirement

PROJECTED INCORRECT DOLLARS	58,566
PAYMENT ERROR RATE	0.01
PROJECTED INCORRECT CASES	2,648
CASE ERROR RATE	0.10

DEFICIENCY ATTRIBUTES	PERCENT OF INCORRECT DOLLARS ACCOUNT FOR
A. MAJOR CAUSES OF INCORRECT DOLLARS	
1. Incomplete Develoment/Verification	100.00
2.	
B. MAJOR LOCATIONS OF INCORRECT DOLLARS IN DI PROCESS	
1. Initial Non-medical Entitlement Determination	100.00
2.	
C. MAJOR LOCATIONS OF INCORRECT DOLLARS IN ORGANIZATION	
1. District Office with PSC Review	91.83
2. District Office/Branch Office	8.17
D. MAJOR METHODS OF DISCOVERY OF INCORRECT DOLLARS	
1. State/Local Government Public Records	76.40
2. SSA Records (MBR, SSR, SER, DO/BO, PSC etc.)	15.43
E. MAJOR BICS ASSOCIATED WITH INCORRECT DOLLARS	
1. Wage Earner (A)	100.00
2.	

TABLE V-1

MAJOR DEFICIENCY CAUSES

OVERPAYMENTS AND PAYMENTS TO NOT ENTITLED

APRIL 1979

DEFICIENCY CAUSE	PERCENT OF INCORRECT DOLLARS	PERCENT OF ALL DEFICIENCIES	TOP TWO DEFICIENCY TYPES AS A PERCENT OF INCORRECT DOLLARS DEFICIENCY TYPE	PERCENT
INCORRECT MEDICAL DETERMINATION (NO CE)	33.34	29.72	1. DISABILITY REQUIREMENTS NOT MET 2. ----	100.00
BENEFICIARY FAILED TO REPORT INFORMATION	30.02	30.42	1. DISABILITY REQUIREMENTS NOT MET 2. SCHOOL ATTENDANCE REQUIREMENTS NOT MET	94.98 3.70
INCORRECT MEDICAL DETERMINATION (MEDICAL FACTORS)	23.00	20.42	1. DISABILITY REQUIREMENTS NOT MET 2. ----	100.00
FAILURE TO FOLLOW-UP ON DIARIED CHANGES	5.11	3.80	1. DISABILITY REQUIREMENTS NOT MET 2. ----	100.00
INCORRECT PROCESSING OF MANUAL ACTION	2.57	3.38	1. DISABILITY REQUIREMENTS NOT MET 2. APPLICATION REQUIREMENTS NOT MET	94.60 3.78
INCORRECT APPLICATION OF POLICY	0.95	0.99	1. DISABILITY REQUIREMENTS NOT MET 2. ----	100.00
INCOMPLETE DEVELOPMENT/ VERIFICATION	0.91	1.83	1. DISABILITY REQUIREMENTS NOT MET 2. CHILD REQUIREMENTS NOT MET	76.82 10.98
THIRD PARTY FAILED TO REPORT INFORMATION	0.90	1.41	1. DISABILITY REQUIREMENTS NOT MET 2. DEATH OF BENEFICIARY	54.79 45.21

TABLE V-2

MAJOR DEFICIENCY CAUSES

UNDERPAYMENTS

APRIL 1979

DEFICIENCY CAUSE	PERCENT OF INCORRECT DOLLARS	PERCENT OF ALL DEFICIENCIES	TOP TWO DEFICIENCY TYPES AS A PERCENT OF INCORRECT DOLLARS	
			DEFICIENCY TYPE	PERCENT
BENEFICIARY FAILED TO REPORT INFORMATION	26.03	8.55	1. WORKMEN'S COMPENSATION OFFSET 2. INCORRECT COMPUTATION OF BENEFIT AMOUNT	98.96 1.04
INCORRECT PROCESSING OF MANUAL ACTION	19.15	16.24	1. WORKMEN'S COMPENSATION OFFSET 2. INCORRECT COMPUTATION OF BENEFIT AMOUNT	74.13 22.89
INCORRECT DETERMINATION (MEDICAL FACTORS)	12.67	16.24	1. WORKMEN'S COMPENSATION OFFSET 2. INCORRECT COMPUTATION OF BENEFIT AMOUNT	47.09 41.06
NO ACTION TAKEN ON REPORTED POST-ENTITLEMENT CHANGE	9.94	3.42	1. WORKMEN'S COMPENSATION OFFSET 2. WAGES INCORRECT	90.89 9.11
INCOMPLETE DEVELOPMENT/ VERIFICATION	8.66	15.38	1. WAGES INOORRECT 2. AGE REQUIREMENT	56.91 18.94
FAILURE TO FOLLOW-UP ON DIARIED CHANGE	7.87	6.84	1. WORKMEN'S COMPENSATION OFFSET 2. INCORRECT COMPUTATION OF BENEFIT AMOUNT	95.27 4.73
BENEFICIARY PROVIDED INCOMPLETE OR INCORRECT INFORMATION	4.81	1.71	1. MISCELLANEOUS PAYMENT DEFICIENCY 2. SELF-EMPLOYMENT EARNINGS INCOMPLETE	89.18 10.82
SYSTEMS PROCESSING	4.69	13.68	1. INCORRECT COMPUTATION OF BENEFIT AMOUNT 2. WORKMEN'S COMPENSATION OFFSET	63.35 26.65

ATTACHMENT 2

DI Profiles

One section of the Disability Amendments of 1980 required that continuing disability under Title II be reviewed at least every three years, except in cases involving a finding of permanent disability. To assist in determining which cases should be reviewed in 1981, the cases from the DI pilot study were profiled using a system similar to the one that has been utilized in the SSI program. The goal of profiling is to identify characteristics of groups of cases with high payment error as distinct from groups of cases with low payment error. Cases containing the characteristics of the high error groups are then targeted for review in 1981.

The technique used to profile the DI Pilot I cases employs repeated application of one-way analysis of variance (ANOVA) as its basic protocol. The operational form of this technique is contained in a commercial computer program purchased from the Institute for Social Research, University of Michigan. The program is called Automatic Interaction Detection (AID).

With reference to the DI Pilot I sample cases, two sources of data are used for the operation of the AID program: a) case characteristics from the Master Beneficiary Record (MBR), and b) payment error data from the DI pilot. The AID program proceeds to test the relationship between case characteristics and payment error. Briefly, using the ANOVA process, it determines the MBR characteristic which best distinguishes between high error and low error and the values for that characteristic which indicate high and low error. It then splits the data set into two groups based on this analysis. The program then looks at both of these groups individually and again examines all MBR characteristics to further split these groups into high and low error. This splitting process continues until further splits are no longer determined to be significant.

The final result is a set of groups, or profiles, to one of which each case in the sample is assigned, and the average dollar error per case within each group. The profiles exhibit wide differences in the average dollar error per case; reviewing the groups with the high average dollar error will result in a higher payoff than reviewing groups with low average dollar error.

The results of the AID analysis are graphically depicted on a tree diagram. This diagram shows the splitting process starting with the total sample and moving sequentially from left to right through each split. The information is also summarized in chart form on the Profile Summary which provides a numbered listing of all profiles with its description in terms of the MBR characteristics. In addition, the summary chart shows for each profile the average dollar error per error case, the average dollar error for all cases and the percent of the total sample which falls in the profile. The AID program also produces backup sheets which give in depth information concerning discrepancy rates and deficiency information for each profile.

The attached profile package is the result of the AID analysis of the DI Pilot I cases. These profiles were produced to target cases for review in 1981. In profiling the pilot I cases, only those cases where the errors were caused by medical factors were considered as error cases. Cases with errors caused by non-medical factors were considered no-error cases.

The AID program identified 20 profile groups with the average dollar error per case ranging from $26 to $311. The average dollar error per error case ranged from $155 to $701. The two following tables provide pertinent data for the 11 most error prone profiles. As shown on Table I, these 11 profiles included only 30.7 percent of the total sample but contained 60.4 percent of the payment error.

Cases are being selected for review in 1981 based on the characteristics of profiles 10 and 12-20. These cases will be sent to the State agencies for review beginning in May. (Profile 10, rather than profile 11, is being used to select cases becauses the characteristics were similar to those of profile 15. This actually resulted in simplifying the computer programming for case selections.)

TABLE I

DI Profiles - Medical Discrepancies Only - Average Dollar Error

Profile	% Error Dollars	% Total Cases	No. of Cases Population	Running Total % Error Dollars	Running Total % Total Cases	Running Total No. of Cases Population
20	7.2	1.4	38,600	7.2	1.4	38,600
19	5.5	1.6	44,100	12.7	3.0	82,700
18	4.8	1.4	38,600	17.5	4.4	121,300
17	5.9	2.1	57,900	23.4	6.5	179,200
16	3.6	1.5	41,400	27.0	8.0	220,600
15	10.0	4.9	135,100	37.0	12.9	355,700
14	3.8	2.4	66,200	40.8	15.3	421,900
13	1.9	1.3	35,800	42.7	16.6	457,700
12	5.4	3.6	99,300	48.1	20.2	557,000
11	11.0	9.3	256,500	59.1	29.5	813,500
10	1.3	1.2	33,100	60.4	30.7	846,600

TABLE II

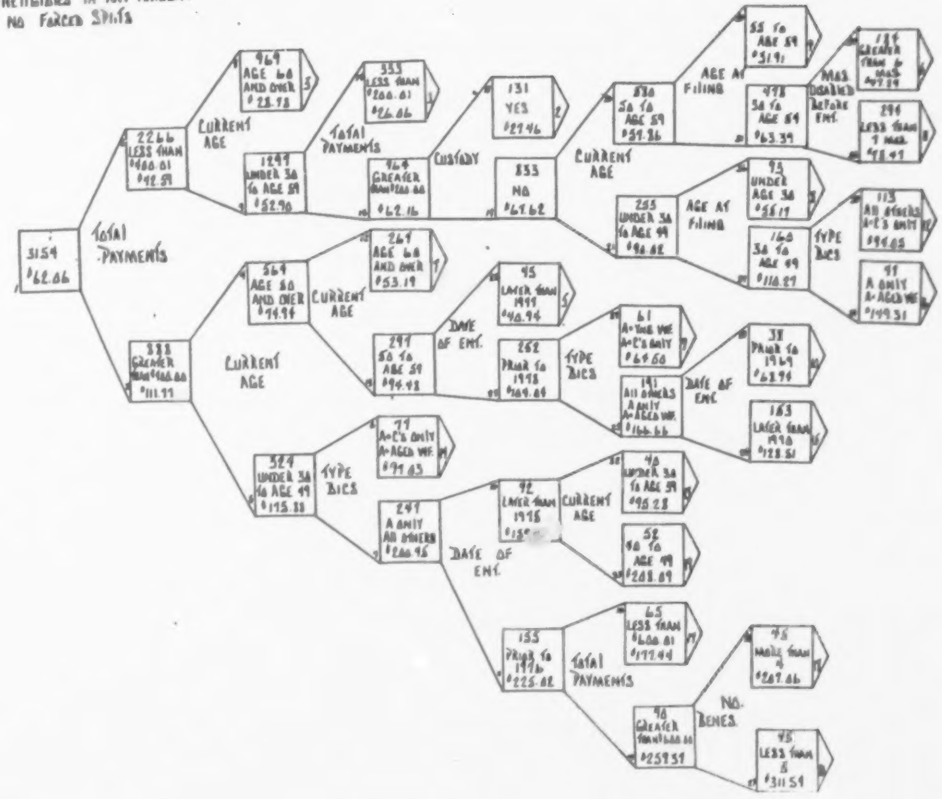
DI Profiles Summary

Profile	Number of Cases (Projected)*	Percent of Total Cases	Percent of Error Dollars	Case Error Rate (%)	Payment Error Rate (%)	Average Dollars in Error All Cases	Average Dollars in Error Error Cases
20	38,600	1.4	7.2	44.4	43.0	$311.54	$700.97
19	44,100	1.6	5.5	32.7	31.5	$208.09	$636.52
18	38,600	1.4	4.8	28.9	28.3	$207.06	$716.75
17	57,900	2.1	5.9	35.4	35.3	$177.44	$501.45
16	41,400	1.5	3.6	48.9	48.2	$149.31	$305.11
15	135,100	4.9	10.0	23.5	21.7	$128.51	$546.16
14	66,200	2.5	3.8	19.5	19.1	$ 97.03	$498.11
13	35,800	1.3	1.9	15.0	12.3	$ 95.28	$635.20
12	99,300	3.6	5.4	31.0	30.9	$ 94.05	$303.65
11	256,500	9.3	11.0	24.8	24.0	$ 73.47	$295.91
10	33,100	1.2	1.3	13.2	12.9	$ 68.94	$523.94

*Based on DI population - December 1980

ALL PROFILES
AVERAGE DOLLAR ERROR PER CASE
DEFINITION OF ERROR: CASES CODED WITH
A MEDICAL DISCREPANCY FACTOR HAVING OVERPAYMENTS
OF FIVE DOLLARS OR MORE OR PAYMENTS TO
INELIGIBLES IN ANY AMOUNT
NO FORCED SPLITS

D-FILE TREE


3154
$62.06
TOTAL PAYMENTS
2266
LESS THAN $400.01
$42.59
CURRENT AGE
969
AGE 60 AND OVER
$23.73
1297
UNDER 30 TO AGE 59
$52.90
TOTAL PAYMENTS
333
LESS THAN $200.01
$26.06
964
GREATER THAN $200.00
$62.16
CUSTODY
131
YES
$27.46
833
NO
$67.62
CURRENT AGE
578
30 TO AGE 59
$59.36
AGE AT FILING
55 TO AGE 59
$31.91
478
30 TO AGE 54
$63.39
MOS. DISABLED BEFORE ENT.
184
GREATER THAN 6 MOS.
$47.59
294
LESS THAN 7 MOS.
$73.41
255
UNDER 30 TO AGE 49
$96.02
AGE AT FILING
95
UNDER AGE 30
$55.17
160
30 TO AGE 49
$116.27
TYPE BICS
113
ALL OTHERS A-C'S ONLY
$94.05
91
A ONLY A-AGED WF.
$149.31
888
GREATER THAN $400.00
$111.77
CURRENT AGE
564
AGE 50 AND OVER
$74.94
CURRENT AGE
269
AGE 60 AND OVER
$53.19
297
50 TO AGE 59
$94.43
DATE OF ENT.
95
LATER THAN 1977
$40.94
262
PRIOR TO 1978
$109.84
TYPE BICS
61
A-THE WF. A-C'S ONLY
$64.60
191
ALL OTHERS A ONLY A-AGED WF.
$166.66
DATE OF ENT.
38
PRIOR TO 1969
$63.94
153
LATER THAN 1970
$128.51
324
UNDER 30 TO AGE 49
$175.33
TYPE BICS
77
A-C'S ONLY A-AGED WF.
$97.03
247
A ONLY ALL OTHERS
$200.95
DATE OF ENT.
92
LATER THAN 1975
CURRENT AGE
40
UNDER 30 TO AGE 59
$95.28
52
40 TO AGE 49
$203.09
155
PRIOR TO 1976
$225.02
TOTAL PAYMENTS
65
LESS THAN $600.01
$177.44
90
GREATER THAN $600.00
$259.59
NO. BENES
45
MORE THAN 4
$207.06
45
LESS THAN 5
$311.59

IV PROFILES

PROFILE SUMM

AVERAGE DOLLAR ERROR

PROFILES	TOTAL PAYMENTS	CURRENT AGE	TYPE BICS	CUSTODY	DATE OF ENTITLEMENT	NO. OF BENES	AGE AT FILING	MOS. DISABLED BEFORE ENT.	ERROR DOLLARS PER ERROR CASE	AVERAGE DOLLAR ERROR PER CASE	PERCENT OF SAMPLE
1	LESS THAN $200.01	UNDER 30 TO AGE 59							$134.99	$26.06	10.6
2	GREATER THAN $200.00 BUT LESS THAN $400.01	UNDER 30 TO AGE 59		YES					$296.70	$29.46	4.2
3	LESS THAN $400.01	AGE 60 AND OVER							$219.59	$[illegible].19	[illegible]
4	GREATER THAN $200.00 BUT LESS THAN $400.01	50 TO AGE 59		NO			55 TO AGE 59		$291.23	$31.91	3.2
5	GREATER THAN $400.00	50 TO AGE 59			LATER THAN 1979				$464.55	$40.94	1.4
6	GREATER THAN $200.00 BUT LESS THAN $400.01							GREATER THAN 6 MOS.	$291.90	$47.29	5.8
7	GREATER THAN $400.00	AGE 60 AND OVER							$417.79	$53.19	8.5
8	GREATER THAN $200.00 BUT LESS THAN $400.01	UNDER 30 TO AGE 49		NO			UNDER AGE 30		$235.02	$55.17	2.9
9	GREATER THAN $400.00	50 TO AGE 59	A-YNG WIFE A-C'S ONLY		PRIOR TO 1978				$439.16	$64.50	1.9
10	GREATER THAN $400.00	50 TO AGE 59	ALL OTHERS A ONLY A-AGED WIFE		PRIOR TO 1969				$523.94	$68.94	1.2
11	GREATER THAN $200.00 BUT LESS THAN $400.01							LESS THAN 7 MOS.	$295.91	$75.47	9.3
12	GREATER THAN $200.00 BUT LESS THAN $400.01	UNDER 30 TO AGE 49	ALL OTHERS A-C'S ONLY	NO			30 TO AGE 49		$363.65	$94.08	3.6
13	GREATER THAN $400.00	UNDER 30 TO AGE 59	A ONLY ALL OTHERS		LATER THAN 1975				$635.20	$95.28	1.3
14	GREATER THAN $400.00	UNDER 30 TO AGE 49	A-C'S ONLY A-AGED WIFE						$498.11	$97.83	2.4
15	GREATER THAN $400.00	50 TO AGE 59	ALL OTHERS A ONLY A-AGED WIFE		LATER THAN 1970				$596.16	$128.51	4.9
16	GREATER THAN $200.00 BUT LESS THAN $400.01	UNDER 30 TO AGE 49	A ONLY A-AGED WF.	NO			30 TO AGE 49		$365.11	$149.31	1.5
17	GREATER [illegible] LESS THAN $600.01	UNDER 30 TO AGE 49	A ONLY ALL OTHERS		PRIOR TO 1976				$561.95	$177.99	2.1
18	GREATER THAN $600.00	UNDER 30 TO AGE 49	A ONLY ALL OTHERS		PRIOR TO 1976	MORE THAN 4			$716.75	$207.06	1.4
19	GREATER THAN $400.00	40 TO AGE 49	A ONLY ALL OTHERS		LATER THAN 1975				$636.52	$208.09	1.6
20	GREATER THAN $600.00	UNDER 30 TO AGE 49	A ONLY ALL OTHERS		PRIOR TO 1976	LESS THAN 6			$900.97	$311.54	1.4
SAMPLE									$542.99	$62.06	100.0

```
                                          DI - PROFILES
                                               **
                                            .
                                          ****** P E R C E N T A G E   O F : ******     DOLLAR ERROR          DOLLAR ERROR
      CASE ERROR RATE    PAY. ERROR RATE                                              **  PER CASE     **  ** PER ERROR CASE **

PROF.                                     TOTAL     ERROR CASES          DOLLARS

      TOT.   OP     UP I TOT.   OP    UP  I CASES  TOT.   OP     UP I PAID   OP     UP I TOT.    OP     UP I  TOT.   UP     UP
                       I                  I                         I                  I                    I
  1   16.8  16.8    .0 I 16.4  16.4   .0  I  10.6   9.8    9.8   .0 I  4.8   4.4    .0 I  26.06  26.06  .00 I 154.98 154.98  .00
  2    9.9   9.9    .0 I 10.2  10.2   .0  I   6.2   2.3    2.3   .0 I  3.2   1.8    .0 I  27.46  27.46  .00 I 276.70 276.70  .00
  3   13.1  13.1    .0 I 10.7  10.7   .0  I  30.7  22.2   22.2   .0 I 23.8  14.2    .0 I  28.78  28.78  .00 I 219.59 219.59  .00
  4   11.8  11.8    .0 I 10.4  10.4   .0  I   3.2   2.1    2.1   .0 I  2.8   1.7    .0 I  31.91  31.91  .00 I 271.23 271.23  .00
  5    8.9   8.9    .0 I  7.3   7.3   .0  I   1.4    .7     .7   .0 I  2.3    .9    .0 I  40.94  40.94  .00 I 460.55 460.55  .00
  6   17.4  17.4    .0 I 16.9  16.9   .0  I   5.8   5.6    5.6   .0 I  4.7   4.4    .0 I  47.29  47.29  .00 I 271.90 271.90  .00
  7   12.7  12.7    .0 I 10.5  10.5   .0  I   8.5   6.0    6.0   .0 I 12.3   7.3    .0 I  53.19  53.19  .00 I 417.74 417.74  .00
  8   19.4  19.4    .0 I 18.6  18.6   .0  I   2.9   3.2    3.2   .0 I  2.5   2.6    .0 I  55.17  55.17  .00 I 285.02 285.02  .00
  9   14.8  14.8    .0 I 14.5  14.5   .0  I   1.9   1.6    1.6   .0 I  2.5   2.0    .0 I  64.50  64.50  .00 I 437.16 437.16  .00
 10   13.2  13.2    .0 I 12.9  12.9   .0  I   1.2    .9     .9   .0 I  1.8   1.3    .0 I  68.94  68.94  .00 I 523.94 523.94  .00
 11   24.8  24.8    .0 I 24.0  24.0   .0  I   9.3  12.8   12.8   .0 I  8.2  11.0    .0 I  73.47  73.47  .00 I 295.91 295.91  .00
 12   31.0  31.0    .0 I 30.9  30.9   .0  I   3.6   6.1    6.1   .0 I  3.1   5.4    .0 I  94.05  94.05  .00 I 303.65 303.65  .00
 13   15.0  15.0    .0 I 12.3  12.3   .0  I   1.3   1.1    1.1   .0 I  2.8   1.9    .0 I  95.28  95.28  .00 I 635.20 635.20  .00
 14   19.5  19.5    .0 I 19.1  19.1   .0  I   2.4   2.6    2.6   .0 I  3.6   3.8    .0 I  97.03  97.03  .00 I 498.11 498.11  .00
 15   23.5  23.5    .0 I 21.7  21.7   .0  I   4.9   6.3    6.3   .0 I  8.2  10.0    .0 I 128.51 128.51  .00 I 546.16 546.16  .00
 16   48.9  48.9    .0 I 48.2  48.2   .0  I   1.5   4.0    4.0   .0 I  1.3   3.6    .0 I 149.31 149.31  .00 I 305.11 305.11  .00
 17   35.4  35.4    .0 I 35.3  35.3   .0  I   2.1   4.0    4.0   .0 I  3.0   5.9    .0 I 177.44 177.44  .00 I 501.45 501.45  .00
 18   28.9  28.9    .0 I 28.3  28.3   .0  I   1.4   2.3    2.3   .0 I  3.0   4.8    .0 I 207.06 207.06  .00 I 716.75 716.75  .00
 19   32.7  32.7    .0 I 31.5  31.5   .0  I   1.6   3.0    3.0   .0 I  3.1   5.5    .0 I 208.09 208.09  .00 I 636.52 636.52  .00
 20   44.4  44.4    .0 I 43.0  43.0   .0  I   1.4   3.5    3.5   .0 I  3.0   7.2    .0 I 311.54 311.54  .00 I 700.97 700.97  .00
TOT   18.1  18.1    .0 I 17.8  17.8   .0  I 100.0 100.0  100.0   .0 I100.0 100.0    .0 I  62.06  62.06  .00 I 342.79 342.79  .00
```

	*** NUMBER OF: ***					*** SAMPLING VARIABILITY ***						
							DOLLAR ERROR PER CASE			DOLLAR ERROR PER ERROR CASE		
PROF.	CASES	ERRORS	OP	UP	AVE. $ PAID PER CASE	CASE ERROR RATE	TOT.	OP	UP	TOT.	OP	UP
1	333 (297935)	56	56	0	158.81	4.0	6.40	6.40	.00	8.57	8.57	.00
2	131 (115632)	13	13	0	269.31	5.1	14.44	14.44	.00	26.46	26.46	.00
3	969 (855325)	127	127	0	270.19	2.1	5.19	5.19	.00	17.37	17.37	.00
4	102 (90034)	12	12	0	306.34	6.3	17.25	17.25	.00	23.41	23.41	.00
5	45 (39720)	4	4	0	564.07	8.3	38.77	38.77	.00	22.64	22.64	.00
6	184 (162414)	32	32	0	280.20	5.5	15.30	15.30	.00	19.43	19.43	.00
7	267 (235677)	34	34	0	505.36	4.0	18.24	18.24	.00	57.63	57.63	.00
8	93 (82090)	18	18	0	295.81	8.0	23.32	23.32	.00	19.87	19.87	.00
9	61 (53844)	9	9	0	444.36	8.9	39.28	39.28	.00	13.63	13.63	.00
10	38 (33542)	5	5	0	534.76	10.7	57.72	57.72	.00	72.47	72.47	.00
11	294 (259510)	73	73	0	306.29	6.9	15.03	15.03	.00	13.76	13.76	.00
12	113 (99743)	35	35	0	306.07	8.5	26.55	26.55	.00	17.45	17.45	.00
13	40 (35307)	6	6	0	774.55	11.1	73.65	73.65	.00	136.12	136.12	.00
14	77 (67967)	15	15	0	508.86	8.8	45.02	45.02	.00	40.63	40.63	.00
15	153 (135051)	36	36	0	591.01	6.7	37.67	37.67	.00	33.98	33.98	.00
16	47 (41486)	23	23	0	309.60	14.3	45.74	45.74	.00	25.25	25.25	.00
17	65 (57374)	23	23	0	502.88	11.6	59.48	59.48	.00	26.83	26.83	.00
18	45 (39720)	13	13	0	731.27	13.2	96.22	96.22	.00	23.79	23.79	.00
19	52 (45899)	17	17	0	661.00	12.7	85.70	85.70	.00	78.32	78.32	.00
20	45 (39720)	20	20	0	725.18	14.5	105.06	105.06	.00	48.16	48.16	.00
TOTAL	3156 (2784000)	571	571	0	348.82	1.3	5.31	5.31	.00	14.62	14.62	.00

DI - PROFILES

PERCENT OF CASES = 100.0
CASE ERROR RATE = 18.1
DOLLAR ERROR RATE
O/P 17.8 U/P .0
AVE. DOLLAR ERROR = 67.06

ALL PROFILES

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.3
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.1
MARRIAGE TO W/E REQ NT MET....	.1
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.1
DIVORCE/ANNUL REQ NOT MET......	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMT NOT MET......	.0
CHILD-IN-CARE PROV RQ.N.M......	.0
MARRIAGE AS TERMINAT EVENT....	.1
SCHOOL ATTENDENCE RQ.N.M.......	.4
ENTITLEMT/DEATH REQ N.MET......	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT..................	2.4
NOT DISABLD-MEDICAL FACTOR....	90.0
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF......	.1
INCOPREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.1
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.4
MEDICARE (SMI)..................	.0
COMPUTATN BENEFT AMT INCOR....	5.6
EARNINGS TEST REQ NOT MET......	.0
OTHER..........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	1.6
INCOR DETERMINATION-NONMED....	1.8
INCORRECT DETERMINATION-MED...	21.4
INCOR DET MED-NO CONS EXAM....	31.2
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.1
INCORRECT APPLICATN-POLICY....	1.6
NO FOLLOW UP-DIARY CHANGES....	4.6
INCOR PROCSSG-ADMIN ACTION....	3.2
INCORRECT COMPUTATION..........	.4
INCOR DATA TRANSFER TO SYS....	1.9
SYSTEMS PROCESSING.............	1.6
INCOMP/INCOR INFO FRM BENE....	.1
BENEF FAIL TO REPORT INFO......	27.3
PAYMENT ADJUSTMENT LAG.........	.1
3RD PARTY INCORRECT INFORM....	.4
3RD PARTY FAILED TO REPORT....	1.8
NO ACTION ON 3RD PRTY REPT....	.3
INCOR ACT ON 3RD PRTY REPT....	.3

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT....................	4.0
PAYMENT TO INELIG..............	96.0
UNDERPAYMENT...................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY..................	2.8
REP PAYEE,LEGAL GRDN...	.0
SPOUSE/REL IN HOUSE....	.1
OTHER REL,FRIEND,NGH...	.0
LANDLORD.................	.0
FINANCIAL INST...........	.0
EMPLOYER(PRES/PAST)....	.3
SSA RECORDS..............	33.8
PUBLIC PENS/BENE PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.3
OTHER CONTACT............	62.6

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	3.8
INITIAL MED ENTITLE....	35.5
NMED POST-ENTITLE.......	7.2
MED POST-ENTITLE........	34.7
CONTIN DISAB INVEST....	4.3
RECONSIDERATION.........	6.5
OTHER PROCESS...........	8.0
D.O./BRANCH OFFICE.....	1.0
D.O. OFFICE W/PSC RE...	.6
PSC(INCLUDES O.D.O.)...	18.5
STATE AGENCY............	32.9
OFFICE OF SYSTEMS......	2.4
OFFICE OF INSUR PROG...	.1
OFFICE OF DISAB PRGM...	3.8
OTHER ORGANIZATION.....	12.1
BENEFICIARY.............	28.5

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL..............	100.0
NON-MEDICAL..........	.0

CATEGORY	PCT. OF DCR CASES
ADMIN................	69.4
BENEF................	30.6

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
\$ 0.01 - \$ 4.99	.0	.0	.0
\$ 5.00 - \$ 25.00	.5	.5	.0
\$ 25.01 - \$ 50.00	1.1	1.1	.0
\$ 50.01 - \$ 75.00	.7	.7	.0
\$ 75.01 - \$100.00	2.1	2.1	.0
\$100.01 - \$150.00	6.1	6.1	.0
\$150.01 - \$200.00	10.3	10.3	.0
\$200.01 - \$300.00	26.3	26.3	.0
\$300.01 - \$400.00	22.4	22.4	.0
\$400.01 - \$500.00	13.1	13.1	.0
\$500.01 - \$600.00	6.7	6.7	.0
\$600.01 - \$700.00	4.4	4.4	.0
\$700.01 & ABOVE	6.3	6.3	.0

```
                    DI - PROFILES
                         **

                                        PERCENT OF CASES =    10.6
                                        CASE ERROR RATE  =    16.8
                                          DOLLAR ERROR RATE
                                             O/P  16.4  U/P     .0
                                        AVE. DOLLAR ERROR =   26.06
PROFILE  1
```

```
                                     PCT. OF
DEFICIENCY TYPE                    DEFICIENCIES
---------------                    ------------
APPLICATN REQUIRE. NOT MET....          .0
INSURED STATUS REQ NOT MET....          .0
AGE REQUIREMENT NOT MET.......          .0
MARRIAGE TO W/E REQ NT MET....          .0
PARENT RELATNSH REQ NT MET....          .0
CHILD RELATNSH REQ NOT MET....          .0
DIVORCE/ANNUL REQ NOT MET.....          .0
DEPENDENCY REQURMT NOT MET....          .0
SUPPORT REQUIREMT NOT MET.....          .0
CHILD-IN-CARE PROV RQ.N.M.....          .0
MARRIAGE AS TERMINAT EVENT....          .0
SCHOOL ATTENDENCE RQ.N.M......          .0
ENTITLEMT/DEATH REQ N.MET.....          .0
ENTITLEMT TO OTHER BENEFTS....          .0
EARNINGS SELF-EMPLYMT INCR....          .0
WAGE INCORRECT................          .0
NOT DISABLD-MEDICAL FACTOR....        98.3
DISAB ONSET DATE INCR-MEDF....          .0
WAIT PERIOD REQ.N.M.-NMEDF....          .0
ENGAGED IN ACTIVITY-NMEDF.....          .0
INCORREC MONTH OF ENTITLMT....          .0
DEATH-BENEFY AS TERM EVENT....          .0
TRIAL WORK PERIOD INCR EST....          .0
REFUSAL TO ACEPT VOC REHAB....          .0
WORKMEN'S COMPENSTN OFFSET....         1.7
MEDICARE (SMI)................          .0
COMPUTATN BENEFT AMT INCOR....          .0
EARNINGS TEST REQ NOT MET.....          .0
OTHER.........................          .0
```

```
                                    PCT. OF
DEFICIENCY CAUSE                  DEFICIENCIES
----------------                  ------------
INCOMPLETE DEVELOPMT/VERIF....          .0
INCOR DETERMINATION-NONMED....         1.7
INCORRECT DETERMINATION-MED...        25.9
INCOR DET MED-NO CONS EXAM....        31.0
NO ACTION ON RPT PE CHANGE....          .0
INCORRECT ACTION ON PE CHG....          .0
INCORRECT APPLICATN-POLICY....         1.7
NO FOLLOW UP-DIARY CHANGES....          .0
INCOR PROCSSG-ADMIN ACTION....         6.9
INCORRECT COMPUTATION.........          .0
INCOR DATA TRANSFER TO SYS....          .0
SYSTEMS PROCESSING............          .0
INCOMP/INCOR INFO.FRM BENE....          .0
BENEF FAIL TO REPORT INFO.....        31.0
PAYMENT ADJUSTMENT LAG........          .0
3RD PARTY INCORRECT INFORM....          .0
3RD PARTY FAILED TO REPORT....          .0
NO ACTION ON 3RD PRTY REPT....         1.7
INCOR ACT ON 3RD PRTY REPT....          .0
```

```
                                    PCT. OF
DISCREPANCY EFFECT                 DCR CASES
------------------                 ---------
OVERPAYMENT...................          .0
PAYMENT TO INELIG.............       100.0
UNDERPAYMENT..................          .0
```

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DEFICIENCY                        PCT. OF
IDENTIFIER                      DEFICIENCIES
----------                      ------------
BENEFICIARY.............            1.7
REP PAYEE,LEGAL GRDN....             .0
SPOUSE/REL IN HOUSE.....             .0
OTHER REL,FRIEND,NGH....             .0
LANDLORD................             .0
FINANCIAL INST..........             .0
EMPLOYER(PRES/PAST).....             .0
SSA RECORDS.............            25.9
PUBLIC PENS/BENE PRG....             .0
PRIVATE PENSION FUND....             .0
STATE/LOCAL GOVT REC....             .0
OTHER CONTACT...........            72.4
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                                  PCT. OF
DEFICIENCY LOCATION             DEFICIENCIES
-------------------             ------------
INITIAL NMED ENTITLE....             .0
INITIAL MED ENTITLE.....            34.5
NMED POST-ENTITLE.......             1.7
MED POST-ENTITLE........            37.9
CONTIN DISAB INVEST.....             6.9
RECONSIDERATION.........            10.3
OTHER PROCESS...........             8.6

D.O./BRANCH OFFICE......             .0
D.O. OFFICE W/PSC RE....             .0
PSC(INCLUDES O.D.O.)....            13.5
STATE AGENCY............            37.9
OFFICE OF SYSTEMS.......             .0
OFFICE OF INSUR PROG....             .0
OFFICE OF DISAB PRGM....             1.7
OTHER ORGANIZATION......            13.8
BENEFICIARY.............            31.0
```

```
PRIMARY DISCREPANCY:
--------------------
                  PCT. OF
FACTOR           DCR CASES

MEDICAL............100.0
NON-MEDICAL.......    .0

                  PCT. OF
CATEGORY         DCR CASES

ADMIN.............. 69.6
BENEF.............. 30.4
```

```
INCORRECT              PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT          ALL DCR.   OP DCR.    UP DCR.
--------------          --- ----   -- ----    -- ----
$  0.01 - $  4.99          .0         .0         .0
$  5.00 - $ 25.00          .0         .0         .0
$ 25.01 - $ 50.00         1.8        1.8         .0
$ 50.01 - $ 75.00         1.8        1.8         .0
$ 75.01 - $100.00         1.8        1.8         .0
$100.01 - $150.00        35.7       35.7         .0
$150.01 - $200.00        58.9       58.9         .0
$200.01 - $300.00          .0         .0         .0
$300.01 - $400.00          .0         .0         .0
$400.01 - $500.00          .0         .0         .0
$500.01 - $600.00          .0         .0         .0
$600.01 - $700.00          .0         .0         .0
$700.01 & ABOVE            .0         .0         .0
```

```
                                   DI - PROFILES                      PERCENT OF CASES =      4.2
                                        **                            CASE ERROR RATE  =      9.9
                                                                        DOLLAR ERROR RATE
                                                                            O/P  10.2  U/P     .0
                                                                      AVE. DOLLAR ERROR =   27.46
```

```
PROFILE  2
                                       PCT. OF
DEFICIENCY TYPE                     DEFICIENCIES
----------------                    ------------
APPLICATN REQUIRE. NOT MET....          .0
INSURED STATUS REQ NOT MET....          .0
AGE REQUIREMENT NOT MET.......         6.7
MARRIAGE TO W/E REQ NT MET....          .0
PARENT RELATNSH REQ NT MET....          .0
CHILD RELATNSH REQ NOT MET....          .0
DIVORCE/ANNUL REQ NOT MET.....          .0
DEPENDENCY REQURMT NOT MET....          .0
SUPPORT REQUIREMT NOT MET.....          .0
CHILD-IN-CARE PROV RQ.N.M.....          .0
MARRIAGE AS TERMINAT EVENT....         6.7
SCHOOL ATTENDENCE RQ.N.M......          .0
ENTITLEMT/DEATH REQ N.MET.....          .0
ENTITLEMT TO OTHER BENEFTS....          .0
EARNINGS SELF-EMPLYMT INCR....          .0
WAGE INCORRECT................          .0
NOT DISABLD-MEDICAL FACTOR....        86.7
DISAB ONSET DATE INCR-MEDF....          .0
WAIT PERIOD REQ.N.M.-NMEDF....          .0
ENGAGED IN ACTIVITY-NMEDF.....          .0
INCORREC MONTH OF ENTITLMT....          .0
DEATH-BENEFT AS TERM EVENT....          .0
TRIAL WORK PERIOD INCR EST....          .0
REFUSAL TO ACEPT VOC REHAB....          .0
WORKMEN'S COMPENSTN OFFSET....          .0
MEDICARE (SMI)................          .0
COMPUTATN BENEFT AMT INCOR....          .0
EARNINGS TEST REQ NOT MET.....          .0
OTHER.........................          .0
```

```
                                       PCT. OF
DEFICIENCY CAUSE                    DEFICIENCIES
----------------                    ------------
INCOMPLETE DEVELOPMT/VERIF....          .0
INCOR DETERMINATION-NONMED....          .0
INCORRECT DETERMINATION-MED...         6.7
INCOR DET MED-NO CONS EXAM....        13.3
NO ACTION ON RPT PE CHANGE....          .0
INCORRECT ACTION ON PE CHG....          .0
INCORRECT APPLICATN-POLICY....         6.7
NO FOLLOW UP-DIARY CHANGES....         6.7
INCOR PROCSSG-ADMIN ACTION....         6.7
INCORRECT COMPUTATION.........          .0
INCOR DATA TRANSFER TO SYS....         6.7
SYSTEMS PROCESSING............          .0
INCOMP/INCOR INFO FRM BENE....          .0
BENEF FAIL TO REPORT INFO.....        53.3
PAYMENT ADJUSTMENT LAG........          .0
3RD PARTY INCORRECT INFORM....          .0
3RD PARTY FAILED TO REPORT....          .0
NO ACTION ON 3RD PRTY REPT....          .0
INCOR ACT ON 3RD PRTY REPT....          .0

                                       PCT. OF
DISCREPANCY EFFECT                    DCR CASES
----------- ------                    ---------
OVERPAYMENT.......................       .0
PAYMENT TO INELIG...............100.0
UNDERPAYMENT......................       .0
```

```
DEFICIENCY                  PCT. OF
IDENTIFIER               DEFICIENCIES
----------               ------------
BENEFICIARY...............    6.7
REP PAYEE,LEGAL GRDN......     .0
SPOUSE/REL IN HOUSE.......     .0
OTHER REL,FRIEND,NGH......     .0
LANDLORD..................     .0
FINANCIAL INST............     .0
EMPLOYER(PRES/PAST).......     .0
SSA RECORDS...............   26.7
PUBLIC PENS/BENE PRG......     .0
PRIVATE PENSION FUND......     .0
STATE/LOCAL GOVT REC......     .0
OTHER CONTACT.............   66.7

                              PCT. OF
DEFICIENCY LOCATION        DEFICIENCIES
-------------------        ------------
INITIAL NMED ENTITLE....       6.7
INITIAL MED ENTITLE.....      13.3
NMED POST-ENTITLE.......       6.7
MED POST-ENTITLE........      60.0
CONTIN DISAB INVEST.....       6.7
RECONSIDERATION.........        .0
OTHER PROCESS...........       6.7

D.O./BRANCH OFFICE......       6.7
D.O. OFFICE W/PSC RE....        .0
PSC(INCLUDES O.D.O.)....       6.7
STATE AGENCY............      13.3
OFFICE OF SYSTEMS.......        .0
OFFICE OF INSUR PROG....       6.7
OFFICE OF DISAB PRGM....       6.7
OTHER ORGANIZATION......       6.7
BENEFICIARY.............      53.3
```

```
                                  INCORRECT            PERCENT OF DISCREPANT CASES:
                                  PAYMENT AMOUNT        ALL DCR.   OP DCR.   UP DCR.
                                  --------------        --- ----   -- ----   -- ----
   PRIMARY DISCREPANCY:           $  0.01 - $  4.99        .0         .0        .0
   --------------------           $  5.00 - $ 25.00        .0         .0        .0
                 PCT. OF          $ 25.01 - $ 50.00        .0         .0        .0
FACTOR          DCR CASES         $ 50.01 - $ 75.00        .0         .0        .0
                                  $ 75.01 - $100.00        .0         .0        .0
MEDICAL...........100.0           $100.01 - $150.00        .0         .0        .0
NON-MEDICAL.......   .0           $150.01 - $200.00        .0         .0        .0
                                  $200.01 - $300.00      61.5       61.5        .0
                 PCT. OF          $300.01 - $400.00      38.5       38.5        .0
CATEGORY        DCR CASES         $400.01 - $500.00        .0         .0        .0
                                  $500.01 - $600.00        .0         .0        .0
ADMIN............. 39.5           $400.01 - $700.00        .0         .0        .0
BENEF............. 61.5           $700.01 & ABOVE          .0         .0        .0
```

```
                              DI - PROFILES
                                   **

                                                      PERCENT OF CASES =     30.7
                                                      CASE ERROR RATE  =     13.1
                                                        DOLLAR ERROR RATE
                                                          O/P  10.7  U/P      .0
                                                      AVE. DOLLAR ERROR =    28.78
PROFILE  3
```

```
                                   PCT. OF
DEFICIENCY TYPE                 DEFICIENCIES
---------------                 ------------
APPLICATN REQUIRE. NOT MET....       .0
INSURED STATUS REQ NOT MET....       .0
AGE REQUIREMENT NOT MET.......       .0
MARRIAGE TO W/F REQ NT MET....       .0
PARENT RELATNSH REQ NT MET....       .0
CHILD RELATNSH REQ NOT MET....       .0
DIVORCE/ANNUL REQ NOT MET.....       .0
DEPENDENCY REQURMT NOT MET....       .0
SUPPORT REQUIREMT NOT MET.....       .0
CHILD-IN-CARE PROV RQ.N.M.....       .0
MARRIAGE AS TERMINAT EVENT....       .0
SCHOOL ATTENDENCE RQ.N.M......       .0
ENTITLEMT/DEATH REQ N.MET.....       .0
ENTITLEMT TO OTHER BENEFTS....       .0
EARNINGS SELF-EMPLYMT INCR....       .0
WAGE INCORRECT................       .8
NOT DISABLD-MEDICAL FACTOR....     98.4
DISAB ONSET DATE INCR-MEDF....       .0
WAIT PERIOD REQ.N.M.-NMEDF....       .0
ENGAGED IN ACTIVITY-NMEDF.....       .8
INCORREC MONTH OF ENTITLMT....       .0
DEATH-BENEFY AS TERM EVENT....       .0
TRIAL WORK PERIOD INCR EST....       .0
REFUSAL TO ACEPT VOC REHAB....       .0
WORKMEN'S COMPENSTN OFFSET....       .0
MEDICARE (SMI)................       .0
COMPUTATN BENEFT AMT INCOR....       .0
EARNINGS TEST REQ NOT MET.....       .0
OTHER.........................       .0
```

```
                                       PCT. OF
DEFICIENCY CAUSE                    DEFICIENCIES
----------------                    ------------
INCOMPLETE DEVELOPMT/VERIF....          .8
INCOR DETERMINATION-NONMED....          .8
INCORRECT DETERMINATION-MED...        32.6
INCOR DET MED-NO CONS EXAM....        35.7
NO ACTION ON RPT PE CHANGE....          .0
INCORRECT ACTION ON PE CHG....          .0
INCORRECT APPLICATN-POLICY....         1.6
NO FOLLOW UP-DIARY CHANGES....         1.6
INCOR PROCSSG-ADMIN ACTION....         2.3
INCORRECT COMPUTATION.........          .0
INCOR DATA TRANSFER TO SYS....          .0
SYSTEMS PROCESSING............          .0
INCOMP/INCOR INFO FRM BENE....          .0
BENEF FAIL TO REPORT INFO.....        24.8
PAYMENT ADJUSTMENT LAG........          .0
3RD PARTY INCORRECT INFORM....          .0
3RD PARTY FAILED TO REPORT....          .0
NO ACTION ON 3RD PRTY REPT....          .0
INCOR ACT ON 3RD PRTY REPT....          .0
```

```
                                      PCT. OF
DISCREPANCY EFFECT                   DCR CASES
------------------                   ---------
OVERPAYMENT........................    13.4
PAYMENT TO INELIG..................    55.6
UNDERPAYMENT.......................      .0
```

```
DEFICIENCY                       PCT. OF
IDENTIFIER                    DEFICIENCIES
----------                    ------------
BENEFICIARY...............        1.6
REP PAYEE,LEGAL GRDN......         .0
SPOUSE/REL IN HOUSE.......         .0
OTHER REL,FRIEND,NGH......         .0
LANDLORD..................         .0
FINANCIAL INST............         .0
EMPLOYER(PRES/PAST).......         .0
SSA RECORDS...............       34.9
PUBLIC PENS/GENE PAG......         .0
PRIVATE PENSION FUND......         .0
STATE/LOCAL GOVT REC......         .0
OTHER CONTACT.............       63.6
```

```
                                  PCT. OF
DEFICIENCY LOCATION            DEFICIENCIES
-------------------            ------------
INITIAL NMED ENTITLE......          2.3
INITIAL MED ENTITLE.......         31.9
NMED POST-ENTITLE.........          1.6
MED POST-ENTITLE..........         29.5
CONTIN DISAB INVEST.......          1.6
RECONSIDERATION...........          6.2
OTHER PROCESS.............          7.0

D.O./BRANCH OFFICE........           .8
D.O. OFFICE W/PSC RE......           .8
PSC(INCLUDES O.D.O.)......         16.3
STATE AGENCY..............         47.3
OFFICE OF SYSTEMS.........           .0
OFFICE OF INSUR PROG......           .0
OFFICE OF DISAB PRGM......          1.6
OTHER ORGANIZATION........          8.5
BENEFICIARY...............         24.8
```

```
   PRIMARY DISCREPANCY:
   --------------------
                     PCT. OF
FACTOR              DCR CASES

MEDICAL...........100.0
NON-MEDICAL......    .0

                     PCT. OF
CATEGORY            DCR CASES

ADMIN............. 73.2
BENEF............. 26.8
```

```
INCORRECT              PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT          ALL DCR.   OP DCR.    UP DCR.
--------------          --- ----   -- ----    -- ----
$  0.01 - $  4.99          .0         .0         .0
$  5.00 - $ 25.00         2.4        2.4         .0
$ 25.01 - $ 50.00         3.1        3.1         .0
$ 50.01 - $ 75.00         1.6        1.6         .0
$ 75.01 - $100.00         7.1        7.1         .0
$100.01 - $150.00        11.8       11.8         .0
$150.01 - $200.00        19.7       19.7         .0
$200.01 - $300.00        28.3       28.3         .0
$300.01 - $400.00        26.0       26.0         .0
$400.01 - $500.00          .0         .0         .0
$500.01 - $600.00          .0         .0         .0
$600.01 - $700.00          .0         .0         .0
$700.01 & ABOVE            .0         .0         .0
```

```
                                DI - PROFILES                       PERCENT OF CASES =      3.2
                                     ..                             CASE ERROR RATE  =     11.8
                                                                      DOLLAR ERROR RATE
                                                                         O/P  10.4  U/P    .0
                                                                    AVE. DOLLAR ERROR =   31.91
PROFILE  4
```

```
                                  PCT. OF
DEFICIENCY TYPE                DEFICIENCIES
----------------               ------------
APPLICATN REQUIRE. NOT MET....      .0
INSURED STATUS REQ NOT MET....      .0
AGE REQUIREMENT NOT MET.......      .0
MARRIAGE TO W/E REQ NT MET....      .0
PARENT RELATNSH REQ NT MET....      .0
CHILD RELATNSH REQ NOT MET....      .0
DIVORCE/ANNUL REQ NOT MET.....      .0
DEPENDENCY REQURMT NOT MET....      .0
SUPPORT REQUIREMT NOT MET.....      .0
CHILD-IN-CARE PROV RQ.N.M.....      .0
MARRIAGE AS TERMINAT EVENT....      .0
SCHOOL ATTENDENCE RQ.N.M......      .0
ENTITLEMT/DEATH REQ N.MET.....      .0
ENTITLEMT TO OTHER BENEFTS....      .0
EARNINGS SELF-EMPLYMT INCR....      .0
WAGE INCORRECT................      .0
NOT DISABLD-MEDICAL FACTOR....100.0
DISAB ONSET DATE INCR-MEDF....      .0
WAIT PERIOD REQ.N.M.-NMEDF....      .0
ENGAGED IN ACTIVITY-NMEDF.....      .0
INCORREC MONTH OF ENTITLMT....      .0
DEATH-BENEFY AS TERM EVENT....      .0
TRIAL WORK PERIOD INCR EST....      .0
REFUSAL TO ACEPT VOC REHAB....      .0
WORKMEN'S COMPENSTN OFFSET....      .0
MEDICARE (SMI)................      .0
COMPUTATN BENEFT AMT INCOR....      .0
EARNINGS TEST REQ NOT MET.....      .0
OTHER.........................      .0
```

```
                                    PCT. OF
DEFICIENCY CAUSE                 DEFICIENCIES
----------------                 ------------
INCOMPLETE DEVELOPMT/VERIF....       .0
INCOR DETERMINATION-NONMED....       .0
INCORRECT DETERMINATION-MED...     30.8
INCOR DET MED-NO CONS EXAM....     15.4
NO ACTION ON RPT PE CHANGE....       .0
INCORRECT ACTION ON PE CHG....       .0
INCORRECT APPLICATN-POLICY....       .0
NO FOLLOW UP-DIARY CHANGES....      7.7
INCOR PROCSSG-ADMIN ACTION....       .0
INCORRECT COMPUTATION.........       .0
INCOR DATA TRANSFER TO SYS....       .0
SYSTEMS PROCESSING............       .0
INCOMP/INCOR INFO FRM BENE....       .0
BENEF FAIL TO REPORT INFO.....     46.2
PAYMENT ADJUSTMENT LAG........       .0
3RD PARTY INCORRECT INFORM....       .0
3RD PARTY FAILED TO REPORT....       .0
NO ACTION ON 3RD PRTY REPT....       .0
INCOR ACT ON 3RD PRTY REPT....       .0
```

```
                                   PCT. OF
DISCREPANCY EFFECT                DCR CASES
------------------                ---------
OVERPAYMENT...................       .0
PAYMENT TO INELIG.............    100.0
UNDERPAYMENT..................       .0
```

```
DEFICIENCY                  PCT. OF
IDENTIFIER               DEFICIENCIES
----------               ------------
BENEFICIARY...............     .0
REP PAYEE,LEGAL GRDN......     .0
SPOUSE/REL IN HOUSE.......     .0
OTHER REL,FRIEND,NGH......     .0
LANDLORD..................     .0
FINANCIAL INST............     .0
EMPLOYER(PRES/PAST).......     .0
SSA RECORDS...............   15.4
PUBLIC PENS/BENE PRG......     .0
PRIVATE PENSION FUND......     .0
STATE/LOCAL GOVT REC......     .0
OTHER CONTACT.............   84.6
```

```
                              PCT. OF
DEFICIENCY LOCATION        DEFICIENCIES
-------------------        ------------
INITIAL NMED ENTITLE......      .0
INITIAL MED ENTITLE.......    23.1
NMED POST-ENTITLE.........      .0
MED POST-ENTITLE..........    53.8
CONTIN DISAB INVEST.......      .0
RECONSIDERATION...........    15.4
OTHER PROCESS.............     7.7

D.O./BRANCH OFFICE........      .0
D.O. OFFICE W/PSC RE......      .0
PSC (INCLUDES O.D.O.).....    23.1
STATE AGENCY..............    15.4
OFFICE OF SYSTEMS.........      .0
OFFICE OF INSUR PROG......      .0
OFFICE OF DISAB PRGM......      .0
OTHER ORGANIZATION........    15.4
BENEFICIARY...............    46.2
```

```
  PRIMARY DISCREPANCY:
  --------------------
                 PCT. OF
FACTOR          DCR CASES

MEDICAL............100.0
NON-MEDICAL.......    .0

                 PCT. OF
CATEGORY        DCR CASES

ADMIN.............. 50.0
BENEF.............. 50.0
```

```
INCORRECT              PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT          ALL DCR.   OP DCR.   UP DCR.
--------------          --- ----   -- ----   -- ----
$  0.01 - $  4.99          .0         .0        .0
$  5.00 - $ 25.00          .0         .0        .0
$ 25.01 - $ 50.00          .0         .0        .0
$ 50.01 - $ 75.00          .0         .0        .0
$ 75.01 - $100.00          .0         .0        .0
$100.01 - $150.00          .0         .0        .0
$150.01 - $200.00          .0         .0        .0
$200.01 - $300.00        83.3       83.3        .0
$300.01 - $400.00        16.7       16.7        .0
$400.01 - $500.00          .0         .0        .0
$500.01 - $600.00          .0         .0        .0
$600.01 - $700.00          .0         .0        .0
$700.01 & ABOVE            .0         .0        .0
```

```
                                DI - PROFILES
                                     **

                                                                   PERCENT OF CASES =       1.4
                                                                   CASE ERROR RATE  =       8.9
                                                                     DOLLAR ERROR RATE
                                                                         O/P   7.3  U/P      .0
                                                                   AVE. DOLLAR ERROR =    40.94

PROFILE  5

                                   PCT. OF
DEFICIENCY TYPE                 DEFICIENCIES
---------------                 ------------
APPLICATN REQUIRE. NOT MET....      .0
INSURED STATUS REQ NOT MET....      .0
AGE REQUIREMENT NOT MET.......      .0
MARRIAGE TO W/E REQ NT MET....      .0
PARENT RELATNSH REQ NT MET....      .0
CHILD RELATNSH REQ NOT MET....      .0
DIVORCE/ANNUL REQ NOT MET.....      .0
DEPENDENCY REQURMT NOT MET....      .0
SUPPORT REQUIRMENT NOT MET....      .0
CHILD-IN-CARE PROV RQ.NOM.....      .0
MARRIAGE AS TERMINAT EVENT....      .0
SCHOOL ATTENDENCE RQ.N.M......      .0
ENTITLEMT/DEATH REQ N.MET.....      .0
ENTITLEMT TO OTHER BENEFTS....      .0
EARNINGS SELF-EMPLYMT INCR....      .0
WAGE INCORRECT................      .0
NOT DISABLD-MEDICAL FACTOR....100.0
DISAB ONSET DATE INCR-MEDI....      .0
WAIT PERIOD REQ.N.M.-NMEDF....      .0
ENGAGED IN ACTIVITY-NMEDF.....      .0
INCORREC MONTH OF ENTITLMT....      .0
DEATH-BENEFY AS TERM EVENT....      .0
TRIAL WORK PERIOD INCR EST....      .0
REFUSAL TO ACEPT VOC REHAB....      .0
WORKMEN'S COMPENSTN OFFSET....      .0
MEDICARE (SMI)................      .0
COMPUTATN BENEFT AMT INCOR....      .0
EARNINGS TEST REQ NOT MET.....      .0
OTHER.........................      .0

                                      PCT. OF
DEFICIENCY CAUSE                   DEFICIENCIES
----------------                   ------------
INCOMPLETE DEVELOPMT/VERIF....         .0
INCOR DETERMINATION-NONMED....         .0
INCORRECT DETERMINATION-MED...       25.0
INCOR DET MED-NO CONS EXAM....       50.0
NO ACTION ON RPT PE CHANGE....         .0
INCORRECT ACTION ON PE CHG....         .0
INCORRECT APPLICATN-POLICY....         .0
NO FOLLOW UP-DIARY CHANGES....         .0
INCOR PROCSSG-ADMIN ACTION....         .0
INCORRECT COMPUTATION.........         .0
INCOR DATA TRANSFER TO SYS....         .0
SYSTEMS PROCESSING............         .0
INCOMP/INCOR INFO FRM BENE....         .0
BENEF FAIL TO REPORT INFO.....       25.0
PAYMENT ADJUSTMENT LAG........         .0
3RD PARTY INCORRECT INFORM....         .0
3RD PARTY FAILED TO REPORT....         .0
NO ACTION ON 3RD PRTY REPT....         .0
INCOR ACT ON 3RD PRTY REPT....         .0

                                     PCT. OF
DISCREPANCY EFFECT                  DCR CASES
------------ ------                  ---------
OVERPAYMENT.....................        .0
PAYMENT TO INELIG...............     100.0
UNDERPAYMENT....................        .0

DEFICIENCY                      PCT. OF
IDENTIFIER                   DEFICIENCIES
----------                   ------------
BENEFICIARY.............          .0
REP PAYEE,LEGAL GRDN....          .0
SPOUSE/REL IN HOUSE.....          .0
OTHER REL,FRIEND,NGH....          .0
LANDLORD................          .0
FINANCIAL INST..........          .0
EMPLOYER(PRES/PAST).....          .0
SSA RECORDS.............        25.0
PUBLIC PENS/BENE PRG....          .0
PRIVATE PENSION FUND....          .0
STATE/LOCAL GOVT REC....          .0
OTHER CONTACT...........        75.0

                             PCT. OF
DEFICIENCY LOCATION       DEFICIENCIES
-------------------       ------------
INITIAL NMED ENTITLE....          .0
INITIAL MED ENTITLE.....        75.0
NMED POST-ENTITLE.......          .0
MED POST-ENTITLE........        25.0
CONTIN DISAB INVEST.....          .0
RECONSIDERATION.........          .0
OTHER PROCESS...........          .0

D.O./BRANCH OFFICE......          .0
D.O. OFFICE W/PSC RE....          .0
PSC(INCLUDES O.D.O.)....          .0
STATE AGENCY............        75.0
OFFICE OF SYSTEMS.......          .0
OFFICE OF INSUR PROG....          .0
OFFICE OF DISAB PRGM....          .0
OTHER ORGANIZATION......          .0
BENEFICIARY.............        25.0

PRIMARY DISCREPANCY:
--------------------
                    PCT. OF
FACTOR             DCR CASES

MEDICAL............100.0
NON-MEDICAL........   .0

                    PCT. OF
CATEGORY           DCR CASES

ADMIN.............. 75.0
BENEF.............. 25.0

INCORRECT                PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT            ALL DCR.   OP DCR.   UP DCR.
--------------            --- ----   -- ----   -- ----
$  0.01 - $  4.99            .0         .0        .0
$  5.00 - $ 25.00            .0         .0        .0
$ 25.01 - $ 50.00            .0         .0        .0
$ 50.01 - $ 75.00            .0         .0        .0
$ 75.01 - $100.00            .0         .0        .0
$100.01 - $150.00            .0         .0        .0
$150.01 - $200.00            .0         .0        .0
$200.01 - $300.00            .0         .0        .0
$300.01 - $400.00            .0         .0        .0
$400.01 - $500.00         100.0      100.0        .0
$500.01 - $600.00            .0         .0        .0
$600.01 - $700.00            .0         .0        .0
$700.01 & ABOVE              .0         .0        .0
```

```
                                   DI - PROFILES                          PERCENT OF CASES =     9.8
                                        ..                                CASE ERROR RATE  =    17.4
                                                                            DOLLAR ERROR RATE
                                                                              O/P  16.5  U/P     .0
                                                                          AVE. DOLLAR ERROR =   47.29
PROFILE  6
```

```
                               PCT. OF
DEFICIENCY TYPE              DEFICIENCIES
---------------              ------------
APPLICATN REQUIRE. NOT MET....     .0
INSURED STATUS REQ NOT MET....     .0
AGE REQUIREMENT NOT MET.......     .0
MARRIAGE TO W/E REQ NT MET....     .0
PARENT RELATNSH REQ NT MET....     .0
CHILD RELATNSH REQ NOT MET....     .0
DIVORCE/ANNUL REQ NOT MET.....     .0
DEPENDENCY REQURMT NOT MET....     .0
SUPPORT REQUIREMT NOT MET.....     .0
CHILD-IN-CARE PROV RQ.N.M.....     .0
MARRIAGE AS TERMINAT EVENT....     .0
SCHOOL 'ATTENDENCE RQ.N.M.....     .0
ENTITLEMT/DEATH REQ N.MET.....     .0
ENTITLEMT TO OTHER BENEFTS....     .0
EARNINGS SELF-EMPLYMT INCR....     .0
WAGE INCORRECT................     .0
NOT DISABLD-MEDICAL FACTOR.... 94.1
DISAB ONSET DATE INCR-MEDF....     .0
WAIT PERIOD REQ.N.M.-NMEDF....     .0
ENGAGED IN ACTIVITY-NMEDF.....     .0
INCORREC MONTH OF ENTITLMT....     .0
DEATH-BENEFY AS TERM EVENT....     .0
TRIAL WORK PERIOD INCR EST....     .0
REFUSAL TO ACEPT VOC REHAB....     .0
WORKMEN'S COMPENSTN OFFSET....     .0
MEDICARE (SMI)................     .0
COMPUTATN BENEFT AMT INCOR....  5.9
EARNINGS TEST REQ NOT MET.....     .0
OTHER.........................     .0
```

```
                                   PCT. OF
DEFICIENCY CAUSE                DEFICIENCIES
----------------                ------------
INCOMPLETE DEVELOPMT/VERIF....     .0
INCOR DETERMINATION-NONMED....     .0
INCORRECT DETERMINATION-MED... 23.5
INCOR DET MED-NO CONS EXAM.... 35.3
NO ACTION ON RPT PE CHANGE....     .0
INCORRECT ACTION ON PE CHG....     .0
INCORRECT APPLICATN-POLICY....     .0
NO FOLLOW UP-DIARY CHANGES....  2.9
INCOR PROCSSG-ADMIN ACTION....     .0
INCORRECT COMPUTATION.........     .0
INCOR DATA TRANSFER TO SYS....     .0
SYSTEMS PROCESSING............  5.9
INCOMP/INCOR INFO FRM BENE....     .0
BENEF FAIL TO REPORT INFO..... 32.4
PAYMENT ADJUSTMENT LAG........     .0
3RD PARTY INCORRECT INFORM....     .0
3RD PARTY FAILED TO REPORT....     .0
NO ACTION ON 3RD PRTY REPT....     .0
INCOR ACT ON 3RD PRTY REPT....     .0
```

```
                                   PCT. OF
DISCREPANCY EFFECT                DCR CASES
------------------                ---------
OVERPAYMENT...................      .0
PAYMENT TO INELIG.............   100.0
UNDERPAYMENT..................      .0
```

```
DEFICIENCY                     PCT. OF
IDENTIFIER                   DEFICIENCIES
----------                   ------------
BENEFICIARY.............        5.9
REP PAYEE,LEGAL GRDN....         .0
SPOUSE/REL IN HOUSE.....         .0
OTHER REL,FRIEND,NGH....         .0
LANDLORD................         .0
FINANCIAL INST..........         .0
EMPLOYER(PRES/PAST).....         .0
SSA RECORDS.............       35.3
PUBLIC PENS/BENE PRG....         .0
PRIVATE PENSION FUND....         .0
STATE/LOCAL GOVT REC....         .0
OTHER CONTACT...........       58.8
```

```
                                PCT. OF
DEFICIENCY LOCATION          DEFICIENCIES
-------------------          ------------
INITIAL NMED ENTITLE....         .0
INITIAL MED ENTITLE.....       44.1
NMED POST-ENTITLE.......        5.9
MED POST-ENTITLE........       35.3
CONTIN DISAB INVEST.....         .0
RECONSIDERATION.........        2.9
OTHER PROCESS...........       11.8

D.O./BRANCH OFFICE......         .0
D.O. OFFICE W/PSC RE....         .0
PSC(INCLUDES O.D.O.)....       14.7
STATE AGENCY............       32.4
OFFICE OF SYSTEMS.......        5.9
OFFICE OF INSUR PROG....         .0
OFFICE OF DISAB PRGM....         .0
OTHER ORGANIZATION......       14.7
BENEFICIARY.............       32.4
```

```
  PRIMARY DISCREPANCY:
  --------------------
                      PCT. OF
FACTOR               DCR CASES

MEDICAL.............100.0
NON-MEDICAL.........    .0

                      PCT. OF
CATEGORY             DCR CASES

ADMIN...............  65.6
BENEF...............  34.4
```

```
INCORRECT                PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT            ALL DCR.   OP DCR.    UP DCR.
--------------            --- ----   -- ----    -- ----
$   0.01 - $   4.99          .0         .0         .0
$   5.00 - $  25.00          .0         .0         .0
$  25.01 - $  50.00          .0         .0         .0
$  50.01 - $  75.00          .0         .0         .0
$  75.01 - $ 100.00          .0         .0         .0
$ 100.01 - $ 150.00          .0         .0         .0
$ 150.01 - $ 200.00          .0         .0         .0
$ 200.01 - $ 300.00        65.6       65.6         .0
$ 300.01 - $ 400.00        34.4       34.4         .0
$ 400.01 - $ 500.00          .0         .0         .0
$ 500.01 - $ 600.00          .0         .0         .0
$ 600.01 - $ 700.00          .0         .0         .0
$ 700.01 & ABOVE             .0         .0         .0
```

DI - PROFILES
**

PERCENT OF CASES = 8.5
CASE ERROR RATE = 12.7
DOLLAR ERROR RATE
O/P 10.5 U/P .0
AVE. DOLLAR ERROR = 53.19

PROFILE 7

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M.....	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL' ATTENDENCE R.N.M.......	2.5
ENTITLEMT/DEATH REQ N.MET.....	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT..................	2.5
NOT DISABLD-MEDICAL FACTOR....	95.0
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI)..................	.0
COMPUTATN BENEFT AMT INCOR....	.0
EARNINGS TEST REQ NOT MET.....	.0
OTHER............................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	.0
INCOR DETERMINATION-NONMED....	.0
INCORRECT DETERMINATION-MED...	17.5
INCOR DET MED-NO CONS EXAM....	42.5
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	.0
NO FOLLOW UP-DIARY CHANGES....	2.5
INCOR PROCSSG-ADMIN ACTION....	.0
INCORRECT COMPUTATION..........	.0
INCOR DATA TRANSFER TO SYS....	2.5
SYSTEMS PROCESSING.............	.0
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO.....	27.5
PAYMENT ADJUSTMENT LAG.........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	7.5
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY...............	5.0
REP PAYEE,LEGAL GRDN...	.0
SPOUSE/REL IN HOUSE....	.0
OTHER REL,FRIEND,NGH...	.0
LANDLORD.................	.0
FINANCIAL INST..........	.0
EMPLOYER(PRES/PAST)....	.0
SSA RECORDS.............	35.0
PUBLIC PENS/BENE PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.0
OTHER CONTACT...........	60.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT....................	14.7
PAYMENT TO INELIG.............	85.3
UNDERPAYMENT..................	.0

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	2.5
INITIAL MED ENTITLE....	45.0
NMED POST-ENTITLE......	2.5
MED POST-ENTITLE.......	35.0
CONTIN DISAB INVEST....	2.5
RECONSIDERATION........	7.5
OTHER PROCESS..........	5.0
D.O./BRANCH OFFICE.....	2.5
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	7.5
STATE AGENCY............	47.5
OFFICE OF SYSTEMS......	.0
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	.0
OTHER ORGANIZATION.....	15.0
BENEFICIARY.............	27.5

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL...........	100.0
NON-MEDICAL......	.0

CATEGORY	PCT. OF DCR CASES
ADMIN.............	73.5
BENEF.............	26.5

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	2.9	2.9	.0
$ 50.01 - $ 75.00	2.9	2.9	.0
$ 75.01 - $100.00	5.9	5.9	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	2.9	2.9	.0
$200.01 - $300.00	.0	.0	.0
$300.01 - $400.00	8.8	8.8	.0
$400.01 - $500.00	52.9	52.9	.0
$500.01 - $600.00	17.6	17.6	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	5.9	5.9	.0

PERCENT OF CASES = 2.9
CASE ERROR RATE = 19.4
DOLLAR ERROR RATE
O/P 18.6 U/P .0
AVE. DOLLAR ERROR = 55.17

PROFILE 8

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET.......	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMENT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M......	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M......	.0
ENTITLEMT/DEATH REQ N.MET.....	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT................	5.3
NOT DISABLD-MEDICAL FACTOR....	94.7
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI)................	.0
COMPUTATN BENEFT AMT INCOR....	.0
EARNINGS TEST REQ NOT MET.....	.0
OTHER.........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	.0
INCOR DETERMINATION-NONMED....	.0
INCORRECT DETERMINATION-MED...	15.8
INCOR DET MED-NO CONS EXAM....	15.8
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	10.5
NO FOLLOW UP-DIARY CHANGES....	.0
INCOR PROCSSG-ADMIN ACTION....	.0
INCORRECT COMPUTATION.........	.0
INCOR DATA TRANSFER TO SYS....	.0
SYSTEMS PROCESSING............	.0
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO.....	57.9
PAYMENT ADJUSTMENT LAG........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	.0
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT...................	.0
PAYMENT TO INELIG.............	100.0
UNDERPAYMENT..................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY.............	.0
REP PAYEE,LEGAL GRDN...	.0
SPOUSE/REL IN HOUSE....	.0
OTHER REL,FRIEND,NGH...	.0
LANDLORD...............	.0
FINANCIAL INST.........	.0
EMPLOYER(PRES/PAST)....	.0
SSA RECORDS............	21.1
PUBLIC PENS/BENE PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.0
OTHER CONTACT..........	78.9

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	.0
INITIAL MED ENTITLE....	15.8
NMED POST-ENTITLE......	10.5
MED POST-ENTITLE.......	47.4
CONTIN DISAB INVEST....	10.5
RECONSIDERATION........	5.3
OTHER PROCESS..........	10.5
D.O./BRANCH OFFICE.....	.0
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	10.5
STATE AGENCY...........	15.8
OFFICE OF SYSTEMS......	.0
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	5.3
OTHER ORGANIZATION.....	10.5
BENEFICIARY............	57.9

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL..........	100.0
NON-MEDICAL......	.0

CATEGORY	PCT. OF DCR CASES
ADMIN............	38.9
BENEF............	61.1

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	61.1	61.1	.0
$300.01 - $400.00	38.9	38.9	.0
$400.01 - $500.00	.0	.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	.0	.0	.0

DI - PROFILES

PERCENT OF CASES = 1.9
CASE ERROR RATE = 14.8
DOLLAR ERROR RATE
O/P 14.5 U/P .0
AVE. DOLLAR ERROR = 64.50

PROFILE 9

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET.......	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M.....	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M......	.0
ENTITLEMT/DEATH REQ N.MET.....	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT................	.0
NOT DISABLD-MEDICAL FACTOR....	90.0
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI)................	.0
COMPUTATN BENEFT AMT INCOR....	10.0
EARNINGS TEST REQ NOT MET.....	.0
OTHER.........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	.0
INCOR DETERMINATION-NONMED....	.0
INCORRECT DETERMINATION-MED...	20.0
INCOR DET MED-NO CONS EXAM....	30.0
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	.0
NO FOLLOW UP-DIARY CHANGES....	.0
INCOR PROCSSG-ADMIN ACTION....	.0
INCORRECT COMPUTATION.........	.0
INCOR DATA TRANSFER TO SYS....	10.0
SYSTEMS PROCESSING............	.0
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO.....	40.0
PAYMENT ADJUSTMENT LAG........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	.0
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT.....................	.0
PAYMENT TO INELIG...............	100.0
UNDERPAYMENT....................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY.............	.0
REP PAYEE,LEGAL GRDN....	.0
SPOUSE/REL IN HOUSE.....	.0
OTHER REL,FRIEND,NGH....	.0
LANDLORD................	.0
FINANCIAL INST..........	.0
EMPLOYER(PRES/PAST).....	.0
SSA RECORDS.............	50.0
PUBLIC PENS/BENE PRG....	.0
PRIVATE PENSION FUND....	.0
STATE/LOCAL GOVT REC....	.0
OTHER CONTACT...........	50.0

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	.0
INITIAL MED ENTITLE....	40.0
NMED POST-ENTITLE......	10.0
MED POST-ENTITLE.......	30.0
CONTIN DISAB INVEST....	.0
RECONSIDERATION........	.0
OTHER PROCESS..........	20.0
D.O./BRANCH OFFICE.....	.0
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	30.0
STATE AGENCY...........	10.0
OFFICE OF SYSTEMS......	.0
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	.0
OTHER ORGANIZATION.....	20.0
BENEFICIARY............	40.0

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL..........	100.0
NON-MEDICAL......	.0

CATEGORY	PCT. OF DCR CASES
ADMIN............	66.7
BENEF............	33.3

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	.0	.0	.0
$300.01 - $400.00	.0	.0	.0
$400.01 - $500.00	100.0	100.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	.0	.0	.0

```
                                        DI - PROFILES                                  PERCENT OF CASES =     1.2
                                             **                                        CASE ERROR RATE  =    13.2
                                                                                         DOLLAR ERROR RATE
                                                                                           O/P  12.9  U/P    .0
                                                                                       AVE. DOLLAR ERROR =  60.96
PROFILE 10
                                PCT. OF                                         PCT. OF    DEFICIENCY            PCT. OF
DEFICIENCY TYPE              DEFICIENCIES    DEFICIENCY CAUSE                DEFICIENCIES  IDENTIFIER          DEFICIENCIES
---------------              ------------    ----------------                ------------  ----------          ------------
APPLICATN REQUIRE. NOT MET.... 10.0          INCOMPLETE DEVELOPMT/VERIF.... 10.0           BENEFICIARY.............   .0
INSURED STATUS REQ NOT MET....   .0          INCOR DETERMINATION-NONMED....   .0           REP PAYEE,LEGAL GRDN....   .0
AGE REQUIREMENT NOT MET.......   .0          INCORRECT DETERMINATION-MED... 10.0           SPOUSE/REL IN HOUSE.....   .0
MARRIAGE TO W/E REQ NT MET....   .0          INCOR DET MED-NO CONS EXAM.... 30.0           OTHER REL,FRIEND,NGH....   .0
PARENT RELATNSH REQ NT MET....   .0          NO ACTION ON RPT PE CHANGE....   .0           LANDLORD................   .0
CHILD RELATNSH REQ NOT MET....   .0          INCORRECT ACTION ON PE CHG....   .0           FINANCIAL INST..........   .0
DIVORCE/ANNUL REQ NOT MET.....   .0          INCORRECT APPLICATN-POLICY....   .0           EMPLOYER(PRES/PAST).....   .0
DEPENDENCY REQURMT NOT MET....   .0          NO FOLLOW UP-DIARY CHANGES.... 10.0           SSA RECORDS............. 70.0
SUPPORT REQUIREMENT NOT MET...   .0          INCOR PROCSSG-ADMIN ACTION....   .0           PUBLIC PENS/BENE PRG....   .0
CHILD-IN-CARE PROV RQ.N.M.....   .0          INCORRECT COMPUTATION.........   .0           PRIVATE PENSION FUND....   .0
MARRIAGE AS TERMINAT EVENT....   .0          INCOR DATA TRANSFER TO SYS.... 40.0           STATE/LOCAL GOVT REC....   .0
SCHOOL ATTENDENCE RQ.N.M......   .0          SYSTEMS PROCESSING............   .0           OTHER CONTACT........... 30.0
ENTITLEMT/DEATH REQ N.MET.....   .0          INCOMP/INCOR INFO FRM BENE....   .0
ENTITLEMT TO OTHER BENEFTS....   .0          BENEF FAIL TO REPORT INFO.....   .0
EARNINGS SELF-EMPLYMT INCR....   .0          PAYMENT ADJUSTMENT LAG........   .0
WAGE INCORRECT................   .0          3RD PARTY INCORRECT INFORM....   .0
NOT DISABLD-MEDICAL FACTOR.... 50.0          3RD PARTY FAILED TO REPORT....   .0
DISAB ONSET DATE INCR-MEDF....   .0          NO ACTION ON 3RD PRTY REPT....   .0
WAIT PERIOD REQ.N.M.-NMEDF....   .0          INCOR ACT ON 3RD PRTY REPT....   .0                                  PCT. OF
ENGAGED IN ACTIVITY-NMEDF.....   .0                                                        DEFICIENCY LOCATION  DEFICIENCIES
INCORREC MONTH OF ENTITLMT....   .0                                                        -------------------  ------------
DEATH-BENEFY AS TERM EVENT....   .0                                             PCT. OF    INITIAL NMED ENTITLE.... 10.0
TRIAL WORK PERIOD INCR EST....   .0          DISCREPANCY EFFECT                DCR CASES   INITIAL MED ENTITLE..... 20.0
REFUSAL TO ACEPT VOC R.HAB....   .0          ----------- ------                ---------   NMED POST-ENTITLE....... 40.0
WORKMEN'S COMPENSTN OFFSET....   .0          OVERPAYMENT......................   .0        MED POST-ENTITLE........ 10.0
MEDICARE (SMI)................   .0          PAYMENT TO INELIG................100.0        CONTIN DISAB INVEST..... 10.0
COMPUTATN BENEFT AMT INCOR.... 40.0          UNDERPAYMENT.....................   .0        RECONSIDERATION.........   .0
EARNINGS TEST REQ NOT MET.....   .0                                                        OTHER PROCESS........... 10.0
OTHER.........................   .0
                                                                                           D.O./BRANCH OFFICE...... 10.0
                                   INCORRECT            PERCENT OF DISCREPANT CASES:       D.O. OFFICE W/PSC RE....   .0
                                   PAYMENT AMOUNT        ALL DCR.  OP DCR.   UP DCR.       PSC(INCLUDES O.D.O.).... 60.0
                                   --------------        --- ----  -- ----   -- ----       STATE AGENCY............ 20.0
  PRIMARY DISCREPANCY:             $  0.01 - $  4.99        .0        .0        .0         OFFICE OF SYSTEMS.......   .0
  --------------------             $  5.00 - $ 25.00        .0        .0        .0         OFFICE OF INSUR PROG....   .0
                 PCT. OF           $ 25.01 - $ 50.00        .0        .0        .0         OFFICE OF DISAB PRGM....   .0
FACTOR          DCR CASES          $ 50.01 - $ 75.00        .0        .0        .0         OTHER ORGANIZATION...... 10.0
                                   $ 75.01 - $100.00        .0        .0        .0         BENEFICIARY.............   .0
MEDICAL...........100.0            $100.01 - $150.00        .0        .0        .0
NON-MEDICAL.......   .0            $150.01 - $200.00        .0        .0        .0
                                   $200.01 - $300.00        .0        .0        .0
                 PCT. OF           $300.01 - $400.00        .0        .0        .0
CATEGORY        DCR CASES          $400.01 - $500.00      40.0      40.0        .0
                                   $500.01 - $600.00      40.0      40.0        .0
ADMIN.............100.0            $600.01 - $700.00      20.0      20.0        .0
BENEF.............   .0            $700.01 & ABOVE          .0        .0        .0
```

DI - PROFILES

PERCENT OF CASES = 9.3
CASE ERROR RATE = 24.8
DOLLAR ERROR RATE
O/P 24.0 U/P .0
AVE. DOLLAR ERROR = 73.47

PROFILE 11

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET.....	.0
SUPPORT REQUIREMT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M......	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M.......	.0
ENTITLEMT/DEATH REQ N.MET......	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT..................	2.4
NOT DISABLD-MEDICAL FACTOR....	80.2
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	1.2
MEDICARE (SMI).................	.0
COMPUTATN BENEFT AMT INCOR....	7.2
EARNINGS TEST REQ NOT MET.....	.0
OTHER...........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	1.2
INCOR DETERMINATION-NONMED....	1.2
INCORRECT DETERMINATION-MED...	24.1
INCOR DET MED-NO CONS EXAM....	33.7
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	3.6
NO FOLLOW UP-DIARY CHANGES....	2.4
INCOR PROCSSG-ADMIN ACTION....	3.6
INCORRECT COMPUTATION..........	.0
INCOR DATA TRANSFER TO SYS....	.0
SYSTEMS PROCESSING.............	3.6
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO.....	19.3
PAYMENT ADJUSTMENT LAG.........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	.0
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT......................	1.4
PAYMENT TO INELIG...............	98.6
UNDERPAYMENT.....................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY..............	2.4
REP PAYEE,LEGAL GRDN...	.0
SPOUSE/REL IN HOUSE....	.0
OTHER REL,FRIEND,NGH...	.0
LANDLORD.................	.0
FINANCIAL INST..........	.0
EMPLOYER(PRES/PAST)....	.0
SSA RECORDS..............	42.2
PUBLIC PENS/BENE PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.0
OTHER CONTACT...........	55.4

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	1.2
INITIAL MED ENTITLE....	43.4
NMED POST-ENTITLE......	9.6
MED POST-ENTITLE.......	32.5
CONTIN DISAB INVEST....	1.2
RECONSIDERATION........	7.2
OTHER PROCESS..........	4.8
D.O./BRANCH OFFICE.....	.0
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	13.3
STATE AGENCY............	41.0
OFFICE OF SYSTEMS......	3.4
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	14.5
OTHER ORGANIZATION.....	8.4
BENEFICIARY.............	19.3

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL..........	100.0
NON-MEDICAL......	.0

CATEGORY	PCT. OF DCR CASES
ADMIN............	78.1
BENEF............	21.9

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	52.1	52.1	.0
$300.01 - $400.00	47.9	47.9	.0
$400.01 - $500.00	.0	.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	.0	.0	.0

DI - PROFILES
**

PERCENT OF CASES = 3.6
CASE ERROR RATE = 31.0
DOLLAR ERROR RATE
O/P 30.9 U/P .0
AVE. DOLLAR ERROR = 94.05

PROFILE 12

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMENT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M.....	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M.......	.0
ENTITLEMT/DEATH REQ N.MET.....	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT..................	2.5
NOT DISABLD-MEDICAL FACTOR....	92.5
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	2.5
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI).................	.0
COMPUTATN BENEFT AMT INCOR....	2.5
EARNINGS TEST REQ NOT MET.....	.0
OTHER...........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	2.5
INCOR DETERMINATION-NONMED....	.0
INCORRECT DETERMINATION-MED...	12.5
INCOR DET MED-NO CONS EXAM....	32.5
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	[illegible]
INCORRECT APPLICATN-POLICY....	[illegible]
NO FOLLOW UP-DIARY CHANGES....	5.0
INCOR PROCSSG-ADMIN ACTION....	10.0
INCORRECT COMPUTATION.........	.0
INCOR DATA TRANSFER TO SYS....	2.5
SYSTEMS PROCESSING............	2.5
INCOMP/INCOR INFO FRM BENE....	2.5
BENEF FAIL TO REPORT INFO.....	25.0
PAYMENT ADJUSTMENT LAG........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	2.5
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	2.5

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT....................	.0
PAYMENT TO INELIG.............	100.0
UNDERPAYMENT..................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY...........	.0
REP PAYEE,LEGAL GRDN....	.0
SPOUSE/REL IN HOUSE....	2.5
OTHER REL,FRIEND,NGH...	.0
LANDLORD.............	.0
FINANCIAL INST.........	.0
EMPLOYER(PRES/PAST)....	.0
SSA RECORDS...........	22.5
PUBLIC PENS/BENE PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.0
OTHER CONTACT..........	75.0

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	2.5
INITIAL MED ENTITLE....	25.0
NMED POST-ENTITLE......	5.0
MED POST-ENTITLE.......	35.0
CONTIN DISAB INVEST....	17.5
RECONSIDERATION........	2.5
OTHER PROCESS..........	12.5
D.O./BRANCH OFFICE.....	.0
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	17.5
STATE AGENCY...........	32.5
OFFICE OF SYSTEMS......	5.0
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	.0
OTHER ORGANIZATION.....	15.0
BENEFICIARY............	30.0

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL...........	100.0
NON-MEDICAL.......	.0

CATEGORY	PCT. OF DCP CASES
ADMIN.............	65.7
BENEF.............	34.3

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	45.7	45.7	.0
$300.01 - $400.00	54.3	54.3	.0
$400.01 - $500.00	.0	.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	.0	.0	.0

```
                         DI - PROFILES
                              **
                                                        PERCENT OF CASES =      1.3
                                                        CASE ERROR RATE  =     15.0
                                                          DOLLAR ERROR RATE
                                                             O/P  12.3  U/P      .0
                                                        AVE. DOLLAR ERROR =    95.28
PROFILE 13
```

```
                                     PCT. OF
DEFICIENCY TYPE                    DEFICIENCIES
---------------                    ------------
APPLICATN REQUIRE. NOT MET....         .0
INSURED STATUS REQ NOT MET....         .0
AGE REQUIREMENT NOT MET.......         .0
MARRIAGE TO W/E REQ NT MET....         .0
PARENT RELATNSH REQ NT MET....         .0
CHILD RELATNSH REQ NOT MET....         .0
DIVORCE/ANNUL REQ NOT MET.....         .0
DEPENDENCY REQURMT NOT MET....         .0
SUPPORT REQUIREMT NOT MET.....         .0
CHILD-IN-CARE PROV RQ.N.M.....         .0
MARRIAGE AS TERMINAT EVENT....         .0
SCHOOL ATTENDENCE RQ.N.M......         .0
ENTITLEMT/DEATH REQ N.MET.....         .0
ENTITLEMT TO OTHER BENEFTS....         .0
EARNINGS SELF-EMPLYMT INCR....         .0
WAGE INCORRECT................         .0
NOT DISABLD-MEDICAL FACTOR....100.0
DISAB ONSET DATE INCR-MEDF....         .0
WAIT PERIOD REQ.N.M.-NMEDF....         .0
ENGAGED IN ACTIVITY-NMEDF.....         .0
INCORREC MONTH OF ENTITLMT....         .0
DEATH-BENEFT AS TERM EVENT....         .0
TRIAL WORK PERIOD INCR EST....         .0
REFUSAL TO ACEPT VOC REHAB....         .0
WORKMEN'S COMPENSTN OFFSET....         .0
MEDICARE (SMI)................         .0
COMPUTATN BENEFT AMT INCOR....         .0
EARNINGS TEST REQ NOT MET.....         .0
OTHER.........................         .0
```

```
                                     PCT. OF
DEFICIENCY CAUSE                   DEFICIENCIES
----------------                   ------------
INCOMPLETE DEVELOPMT/VERIF....         .0
INCOR DETERMINATION-NONMED....         .0
INCORRECT DETERMINATION-MED...       10.0
INCOR DET MED-NO CONS EXAM....         .0
NO ACTION ON RPT PE CHANGE....         .0
INCORRECT ACTION ON PE CHG....         .0
INCORRECT APPLICATN-POLICY....         .0
NO FOLLOW UP-DIARY CHANGES....       60.0
INCOR PROCSSG-ADMIN ACTION....       10.0
INCORRECT COMPUTATION.........         .0
INCOR DATA TRANSFER TO SYS....         .0
SYSTEMS PROCESSING............         .0
INCOMP/INCOR INFO FRM BENE....         .0
BENEF FAIL TO REPORT INFO.....       20.0
PAYMENT ADJUSTMENT LAG........         .0
3RD PARTY INCORRECT INFORM....         .0
3RD PARTY FAILED TO REPORT....         .0
NO ACTION ON 3RD PRTY REPT....         .0
INCOR ACT ON 3RD PRTY REPT....         .0
```

```
                                    PCT. OF
DISCREPANCY EFFECT                 DCR CASES
------------------                 ---------
OVERPAYMENT...................         .0
PAYMENT TO INELIG.............      100.0
UNDERPAYMENT..................         .0
```

```
DEFICIENCY                          PCT. OF
IDENTIFIER                        DEFICIENCIES
----------                        ------------
BENEFICIARY...............             .0
REP PAYEE,LEGAL GRDN......             .0
SPOUSE/REL IN HOUSE.......             .0
OTHER REL,FRIEND,NGH......             .0
LANDLORD..................             .0
FINANCIAL INST............             .0
EMPLOYER(PRES/PAST).......             .0
SSA RECORDS...............           40.0
PUBLIC PENS/BENE PRG......             .0
PRIVATE PENSION FUND......             .0
STATE/LOCAL GOVT REC......             .0
OTHER CONTACT.............           60.0
```

```
                                    PCT. OF
DEFICIENCY LOCATION               DEFICIENCIES
-------------------               ------------
INITIAL NMED ENTITLE......             .0
INITIAL MED ENTITLE.......           30.0
NMED POST-ENTITLE.........             .0
MED POST-ENTITLE..........           60.0
CONTIN DISAB INVEST.......             .0
RECONSIDERATION...........           10.0
OTHER PROCESS.............             .0

D.O./BRANCH OFFICE........             .0
D.O. OFFICE W/PSC RE......             .0
PSC(INCLUDES O.D.O.)......           70.0
STATE AGENCY..............             .0
OFFICE OF SYSTEMS.........             .0
OFFICE OF INSUR PROG......             .0
OFFICE OF DISAB PRGM......             .0
OTHER ORGANIZATION........           10.0
BENEFICIARY...............           20.0
```

```
   PRIMARY DISCREPANCY:
   --------------------
                    PCT. OF
FACTOR             DCR CASES

MEDICAL...........100.0
NON-MEDICAL.......   .0

                    PCT. OF
CATEGORY           DCR CASES

ADMIN.............. 66.7
BENEF.............. 33.3
```

```
INCORRECT               PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT           ALL DCR.   OP DCR.    UP DCR.
--------------           --- ----   -- ----    -- ----
$   0.01 - $   4.99          .0         .0         .0
$   5.00 - $  25.00          .0         .0         .0
$  25.01 - $  50.00          .0         .0         .0
$  50.01 - $  75.00          .0         .0         .0
$  75.01 - $100.00           .0         .0         .0
$100.01 - $150.00            .0         .0         .0
$150.01 - $200.00            .0         .0         .0
$200.01 - $300.00            .0         .0         .0
$300.01 - $400.00            .0         .0         .0
$400.01 - $500.00          16.7       16.7         .0
$500.01 - $600.00          33.3       33.3         .0
$600.01 - $700.00          16.7       16.7         .0
$700.01 & ABOVE            33.3       33.3         .0
```

```
                                                          DI - PROFILES                 PERCENT OF CASES =     2.4
                                                               ..                       CASE ERROR RATE  =    19.5
                                                                                          DOLLAR ERROR RATE
                                                                                              O/P  19.1  U/P      .0
                                                                                        AVE. DOLLAR ERROR =   97.03

PROFILE 14
                           PCT. OF                              PCT. OF        DEFICIENCY           PCT. OF
DEFICIENCY TYPE         DEFICIENCIES    DEFICIENCY CAUSE        DEFICIENCIES    IDENTIFIER        DEFICIENCIES
---------------         ------------    ----------------        ------------    ----------        ------------
APPLICATN REQUIRE. NOT MET....    .0        INCOMPLETE DEVELOPMT/VERIF....   5.9        BENEFICIARY.............  11.8
INSURED STATUS REQ NOT MET....    .0        INCOR DETERMINATION-NONMED....    .0        REP PAYEE,LEGAL GRDN....    .0
AGE REQUIREMENT NOT MET.......    .0        INCORRECT DETERMINATION-MED...  23.5        SPOUSE/REL IN HOUSE.....    .0
MARRIAGE TO W/E REQ NT MET....    .0        INCOR DET MED-NO CONS EXAM....  11.8        OTHER REL,FRIEND,NGH....    .0
PARENT RELATNSH REQ NT MET....    .0        NO ACTION ON RPT PE CHANGE....    .0        LANDLORD................    .0
CHILD RELATNSH REQ NOT MET....    .0        INCORRECT ACTION ON PE CHG....   5.9        FINANCIAL INST..........    .0
DIVORCE/ANNUL REQ NOT MET.....    .0        INCORRECT APPLICATN-POLICY....    .0        EMPLOYER(PRES/PAST).....    .0
DEPENDENCY REQURMT NOT MET....    .0        NO FOLLOW UP-DIARY CHANGES....  11.8        SSA RECORDS.............  35.3
SUPPORT REQUIREMT NOT MET.....    .0        INCOR PROCSSG-ADMIN ACTION....    .0        PUBLIC PENS/BENE PRG....    .0
CHILD-IN-CARE PROV RQ.N.M.....    .0        INCORRECT COMPUTATION.........  11.8        PRIVATE PENSION FUND....    .0
MARRIAGE AS TERMINAT EVENT....    .0        INCOR DATA TRANSFER TO SYS....    .0        STATE/LOCAL GOVT REC....    .0
SCHOOL ATTENDENCE RQ.N.M......    .0        SYSTEMS PROCESSING............    .0        OTHER CONTACT...........  52.9
ENTITLEMT/DEATH REQ N.MET.....    .0        INCOMP/INCOR INFO FRM BENE....    .0
ENTITLEMT TO OTHER BENEFTS....    .0        BENEF FAIL TO REPORT INFO.....  17.6
EARNINGS SELF-EMPLYMT INCR....    .0        PAYMENT ADJUSTMENT LAG........   5.9
WAGE INCORRECT................   5.9        3RD PARTY INCORRECT INFORM....    .0
NOT DISABLD-MEDICAL FACTOR....  82.4        3RD PARTY FAILED TO REPORT....    .0
DISAB ONSET DATE INCR-MEDF....    .0        NO ACTION ON 3RD PRTY REPT....   5.9
WAIT PERIOD REQ.N.M.-NMEDF....    .0        INCOR ACT ON 3RD PRTY REPT....    .0                             PCT. OF
ENGAGED IN ACTIVITY-NMEDF.....    .0                                                    DEFICIENCY LOCATION DEFICIENCIES
INCORREC MONTH OF ENTITLMT....    .0                                                    ------------------- ------------
DEATH-BENEFY AS TERM EVENT....    .0                                   PCT. OF          INITIAL NMED ENTITLE....  17.6
TRIAL WORK PERIOD INCR EST....    .0        DISCREPANCY EFFECT         DCR CASES        INITIAL MED ENTITLE.....  11.8
REFUSAL TO ACEPT VOC REHAB....    .0        ----------- ------         ---------        NMED POST-ENTITLE.......    .0
WORKMEN'S COMPENSTN OFFSET....    .0        OVERPAYMENT...................    .0        MED POST-ENTITLE........  47.1
MEDICARE (SMI)................    .0        PAYMENT TO INELIG............. 100.0        CONTIN DISAB INVEST.....   5.9
COMPUTATN BENEFIT AMT INCOR...  11.8        UNDERPAYMENT..................    .0        RECONSIDERATION.........  17.6
EARNINGS TEST REQ NOT MET.....    .0                                                    OTHER PROCESS...........    .0
OTHER.........................    .0
                                                                                        D.O./BRANCH OFFICE......    .0
                                                                                        B.O. OFFICE W/PSC RE....    .0
                                INCORRECT             PERCENT OF DISCREPANT CASES:      PSC(INCLUDES O.D.O.)....  17.6
                                PAYMENT AMOUNT        ALL DCR.   OP DCR.    UP DCR.     STATE AGENCY............  29.4
                                --------------        --- ----   -- ----    -- ----     OFFICE OF SYSTEMS.......  17.6
    PRIMARY DISCREPANCY:        $  0.01 - $  4.99         .0         .0         .0      OFFICE OF INSUR PROG....    .0
    --------------------        $  5.00 - $ 25.00         .0         .0         .0      OFFICE OF DISAB PRGM....   5.9
                PCT. OF         $ 25.01 - $ 50.00         .0         .0         .0      OTHER ORGANIZATION......  11.8
FACTOR         DCR CASES        $ 50.01 - $ 75.00         .0         .0         .0      BENEFICIARY.............  17.6
                                $ 75.01 - $100.00         .0         .0         .0
MEDICAL...........100.0         $100.01 - $150.00         .0         .0         .0
NON-MEDICAL.......   .0         $150.01 - $200.00         .0         .0         .0
                                $200.01 - $300.00         .0         .0         .0
                PCT. OF         $300.01 - $400.00         .0         .0         .0
CATEGORY       DCR CASES        $400.01 - $500.00       53.3       53.3         .0
                                $500.01 - $600.00       26.7       26.7         .0
ADMIN............. 80.0         $600.01 - $700.00       20.0       20.0         .0
BENEF............. 20.0         $700.01 & ABOVE           .0         .0         .0
```

DI - PROFILES
**

PERCENT OF CASES = 4.9
CASE ERROR RATE = 23.5
DOLLAR ERROR RATE
O/P 21.7 U/P .0
AVE. DOLLAR ERROR = 128.51

PROFILE 15

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET......	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M.....	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M.......	.0
ENTITLEMT/DEATH REQ N.MET......	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT..................	4.3
NOT DISABLD-MEDICAL FACTOR....	87.2
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORRECT MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI)..................	.0
COMPUTATN BENEFT AMT INCOR....	8.5
EARNINGS TEST REQ NOT MET......	.0
OTHER..........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	.0
INCOR DETERMINATION-NONMED....	2.1
INCORRECT DETERMINATION-MED...	14.9
INCOR DET MED-NO CONS EXAM....	38.3
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	4.3
NO FOLLOW UP-DIARY CHANGES....	2.1
INCOR PROCSSG-ADMIN ACTION....	.0
INCORRECT COMPUTATION..........	.0
INCOR DATA TRANSFER TO SYS....	2.1
SYSTEMS PROCESSING.............	2.1
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO......	27.7
PAYMENT ADJUSTMENT LAG.........	.0
3RD PARTY INCORRECT INFORM....	2.1
3RD PARTY FAILED TO REPORT....	4.3
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT....................	.0
PAYMENT TO INELIG..............	100.0
UNDERPAYMENT...................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY.............	2.1
REP PAYEE,LEGAL GRDN...	.0
SPOUSE/REL IN HOUSE....	.0
OTHER REL,FRIEND,NGH...	.0
LANDLORD................	.0
FINANCIAL INST..........	.0
EMPLOYER(PRES/PAST)....	4.3
SSA RECORDS.............	25.5
PUBLIC PENS/BENF PRG...	.0
PRIVATE PENSION FUND...	.0
STATE/LOCAL GOVT REC...	.0
OTHER CONTACT...........	68.1

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE...	6.4
INITIAL MED ENTITLE....	36.2
NMED POST-ENTITLE......	12.8
MED POST-ENTITLE.......	27.7
CONTIN DISAB INVEST....	4.3
RECONSIDERATION........	8.5
OTHER PROCESS..........	4.3
D.O./BRANCH OFFICE.....	.0
D.O. OFFICE W/PSC RE...	.0
PSC(INCLUDES O.D.O.)...	23.4
STATE AGENCY...........	23.4
OFFICE OF SYSTEMS......	2.1
OFFICE OF INSUR PROG...	.0
OFFICE OF DISAB PRGM...	10.6
OTHER ORGANIZATION.....	10.6
BENEFICIARY............	29.8

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL...........	100.0
NON-MEDICAL.......	.0

CATEGORY	PCT. OF DCR CASES
ADMIN.............	66.7
BENEF.............	33.3

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 30.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	.0	.0	.0
$300.01 - $400.00	.0	.0	.0
$400.01 - $500.00	41.7	41.7	.0
$500.01 - $600.00	25.0	25.0	.0
$600.01 - $700.00	22.2	22.2	.0
$700.01 & ABOVE	11.1	11.1	.0

PERCENT OF CASES = 1.5
CASE ERROR RATE = 48.9
DOLLAR ERROR RATE
O/P 48.2 U/P .0
AVE. DOLLAR ERROR = 149.31

PROFILE 16

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET	.0
INSURED STATUS REQ NOT MET	.0
AGE REQUIREMENT NOT MET	.0
MARRIAGE TO W/E REQ NT MET	.0
PARENT RELATNSH REQ NT MET	.0
CHILD RELATNSH REQ NOT MET	.0
DIVORCE/ANNUL REQ NOT MET	.0
DEPENDENCY REQURMT NOT MET	.0
SUPPORT REQUIREMT NOT MET	.0
CHILD-IN-CARE PROV RQ.N.M.	.0
MARRIAGE AS TERMINAT EVENT	.0
SCHOOL ATTENDENCE RQ.N.M.	.0
ENTITLEMT/DEATH REQ N.MET.	.0
ENTITLEMT TO OTHER BENEFTS	.0
EARNINGS SELF-EMPLYMT INCR	.0
WAGE INCORRECT	.0
NOT DISABLD-MEDICAL FACTOR	86.2
DISAB ONSET DATE INCR-MEDF	.0
WAIT PERIOD REQ.N.M.-NMEDF	.0
ENGAGED IN ACTIVITY-NMEDF	.0
INCORREC MONTH OF ENTITLMT	.0
DEATH-BENEFY AS TERM EVENT	.0
TRIAL WORK PERIOD INCR EST	.0
REFUSAL TO ACEPT VOC REHAB	.0
WORKMEN'S COMPENSTN OFFSET	.0
MEDICARE (SMI)	.0
COMPUTATN BENEFT AMT INCOR	13.8
EARNINGS TEST REQ NOT MET	.0
OTHER	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF	.0
INCOR DETERMINATION-NONMED	10.3
INCORRECT DETERMINATION-MED	17.2
INCOR DET MED-NO CONS EXAM	24.1
NO ACTION ON RPT PE CHANGE	.0
INCORRECT ACTION ON PE CHG	.0
INCORRECT APPLICATN-POLICY	.0
NO FOLLOW UP-DIARY CHANGES	.0
INCOR PROCSSG-ADMIN ACTION	.0
INCORRECT COMPUTATION	.0
INCOR DATA TRANSFER TO SYS	.0
SYSTEMS PROCESSING	3.4
INCOMP/INCOR INFO FRM BENE	.0
BENEF FAIL TO REPORT INFO	37.9
PAYMENT ADJUSTMENT LAG	.0
3RD PARTY INCORRECT INFORM	3.4
3RD PARTY FAILED TO REPORT	3.4
NO ACTION ON 3RD PRTY REPT	.0
INCOR ACT ON 3RD PRTY REPT	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT	.0
PAYMENT TO INELIG	100.0
UNDERPAYMENT	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY	.0
REP PAYEE,LEGAL GRDN.	.0
SPOUSE/REL IN HOUSE	.0
OTHER REL,FRIEND,NGH.	.0
LANDLORD	.0
FINANCIAL INST.	.0
EMPLOYER(PRES/PAST)	.0
SSA RECORDS	24.1
PUBLIC PENS/BENE PRG.	.0
PRIVATE PENSION FUND	.0
STATE/LOCAL GOVT REC.	.0
OTHER CONTACT	75.9

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE.	10.3
INITIAL MED ENTITLE.	13.8
NMED POST-ENTITLE	3.4
MED POST-ENTITLE	44.8
CONTIN DISAB INVEST	6.9
RECONSIDERATION	6.9
OTHER PROCESS	13.8
D.O./BRANCH OFFICE	.0
D.O. OFFICE W/PSC RE.	.0
PSC(INCLUDES O.D.O.)	13.8
STATE AGENCY	20.7
OFFICE OF SYSTEMS	3.4
OFFICE OF INSUR PROG.	.0
OFFICE OF DISAB PRGM.	3.4
OTHER ORGANIZATION	17.2
BENEFICIARY	41.4

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL	100.0
NON-MEDICAL	.0

CATEGORY	PCT. OF DCR CASES
ADMIN.	52.2
BENEF.	47.8

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	43.5	43.5	.0
$300.01 - $400.00	56.5	56.5	.0
$400.01 - $500.00	.0	.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	.0	.0	.0
$700.01 & ABOVE	.0	.0	.0

```
                               DI - PROFILES
                                     **

                                                              PERCENT OF CASES =      2.1
                                                              CASE ERROR RATE  =     35.4
                                                                DOLLAR ERROR RATE
                                                                   O/P  35.3  U/P      .0
                                                              AVE. DOLLAR ERROR =  177.44
PROFILE 17
```

```
                                     PCT. OF
DEFICIENCY TYPE                   DEFICIENCIES
---------------                   ------------
APPLICATN REQUIRE. NOT MET....        2.0
INSURED STATUS REQ NOT MET....         .0
AGE REQUIREMENT NOT MET.......         .0
MARRIAGE TO W/E REQ NT MET....        2.0
PARENT RELATNSH REQ NT MET....         .0
CHILD RELATNSH REQ NOT MET....        2.0
DIVORCE/ANNUL REQ NOT MET.....         .0
DEPENDENCY REQURMT NOT MET....         .0
SUPPORT REQUIREMT NOT MET.....         .0
CHILD-IN-CARE PROV RQ.N.M.....         .0
MARRIAGE AS TERMINAT EVENT....         .0
SCHOOL ATTENDENCE RQ.N.M......        4.0
ENTITLEMT/DEATH REQ N.MET.....         .0
ENTITLEMT TO OTHER BENEFTS....         .0
EARNINGS SELF-EMPLYMT INCR....         .0
WAGE INCORRECT................       10.0
NOT DISABLD-MEDICAL FACTOR....       62.0
DISAB ONSET DATE INCR-MEDF....         .0
WAIT PERIOD REQ.N.M.-NMEDF....         .0
ENGAGED IN ACTIVITY-NMEDF.....         .0
INCORREC MONTH OF ENTITLMT....         .0
DEATH-BENEFT AS TERM EVENT....         .0
TRIAL WORK PERIOD INCR EST....         .0
REFUSAL TO ACEPT VOC REHAB....         .0
WORKMEN'S COMPENSTN OFFSET....        2.0
MEDICARE (SMI)................         .0
COMPUTATN BENEFT AMT INCOR....       16.0
EARNINGS TEST REQ NOT MET.....         .0
OTHER.........................         .0
```

```
    PRIMARY DISCREPANCY:
    --------------------
                   PCT. OF
FACTOR            DCR CASES

MEDICAL............100.0
NON-MEDICAL.......    .0

                   PCT. OF
CATEGORY          DCR CASES

ADMIN............. 60.9
BENEF............. 39.1
```

```
                                         PCT. OF
DEFICIENCY CAUSE                      DEFICIENCIES
----------------                      ------------
INCOMPLETE DEVELOPMT/VERIF....            5.0
INCOR DETERMINATION-NONMED....           13.0
INCORRECT DETERMINATION-MED...            5.0
INCOR DET MED-NO CONS EXAM....           25.0
NO ACTION ON RPT PE CHANGE....             .0
INCORRECT ACTION ON PE CHG....             .0
INCORRECT APPLICATN-POLICY....             .0
NO FOLLOW UP-DIARY CHANGES....            6.0
INCOR PROCSSG-ADMIN ACTION....            6.0
INCORRECT COMPUTATION.........            2.0
INCOR DATA TRANSFER TO SYS....             .0
SYSTEMS PROCESSING............             .0
INCOMP/INCOR INFO FRM BENE....             .0
BENEF FAIL TO REPORT INFO.....           30.0
PAYMENT ADJUSTMENT LAG........             .0
3RD PARTY INCORRECT INFORM....            2.0
3RD PARTY FAILED TO REPORT....            6.0
NO ACTION ON 3RD PRTY REPT....             .0
INCOR ACT ON 3RD PRTY REPT....             .0
```

```
                                        PCT. OF
DISCREPANCY EFFECT                     DCR CASES
----------- ------                     ---------
OVERPAYMENT.......................         .0
PAYMENT TO INELIG.................      100.0
UNDERPAYMENT......................         .0
```

```
INCORRECT                 PERCENT OF DISCREPANT CASES:
PAYMENT AMOUNT             ALL DCR.   OP DCR.    UP DCR.
--------------             --- ----   -- ----    -- ----
$   0.01 - $   4.99           .0         .0         .0
$   5.00 - $  25.00           .0         .0         .0
$  25.01 - $  50.00           .0         .0         .0
$  50.01 - $  75.00           .0         .0         .0
$  75.01 - $ 100.00           .0         .0         .0
$ 100.01 - $ 150.00           .0         .0         .0
$ 150.01 - $ 200.00           .0         .0         .0
$ 200.01 - $ 300.00           .0         .0         .0
$ 300.01 - $ 400.00           .0         .0         .0
$ 400.01 - $ 500.00         52.2       52.2         .0
$ 500.01 - $ 600.00         47.8       47.8         .0
$ 600.01 - $ 700.00           .0         .0         .0
$ 700.01 & ABOVE              .0         .0         .0
```

```
DEFICIENCY                        PCT. OF
IDENTIFIER                     DEFICIENCIES
----------                     ------------
BENEFICIARY...............         4.0
REP PAYEE,LEGAL GRDN......          .0
SPOUSE/REL IN HOUSE.......          .0
OTHER REL,FRIEND,NGH......          .0
LANDLORD..................          .0
FINANCIAL INST............          .0
EMPLOYER(PRES/PAST).......          .0
SSA RECORDS...............        44.0
PUBLIC PENS/BENE PRG......          .0
PRIVATE PENSION FUND......          .0
STATE/LOCAL GOVT REC......         4.0
OTHER CONTACT.............        48.0
```

```
                                  PCT. OF
DEFICIENCY LOCATION            DEFICIENCIES
-------------------            ------------
INITIAL NMED ENTITLE......        12.0
INITIAL MED ENTITLE.......        22.0
NMED POST-ENTITLE.........        26.0
MED POST-ENTITLE..........        28.0
CONTIN DISAB INVEST.......         2.0
RECONSIDERATION...........         8.0
OTHER PROCESS.............         2.0

D.O./BRANCH OFFICE........         4.0
D.O. OFFICE W/PSC RE......         6.0
PSC(INCLUDES O.D.O.)......        32.0
STATE AGENCY..............        14.0
OFFICE OF SYSTEMS.........          .0
OFFICE OF INSUR PROG......          .0
OFFICE OF DISAB PRGM......          .0
OTHER ORGANIZATION........         6.0
BENEFICIARY...............        38.0
```

DI - PROFILES
**

PERCENT OF CASES = 1.4
CASE ERROR RATE = 28.9
DOLLAR ERROR RATE
O/P 28.3, U/P .0
AVE. DOLLAR ERROR = 207.06

PROFILE 18

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET	.0
INSURED STATUS REQ NOT MET	.0
AGE REQUIREMENT NOT MET	.0
MARRIAGE TO W/E REQ NT MET	.0
PARENT RELATNSH REQ NT MET	.0
CHILD RELATNSH REQ NOT MET	.0
DIVORCE/ANNUL REQ NOT MET	.0
DEPENDENCY REQURMT NOT MET	.0
SUPPORT REQUIREMT NOT MET	.0
CHILD-IN-CARE PROV RQ.N.M.	.0
MARRIAGE AS TERMINAT EVENT	.0
SCHOOL ATTENDENCE RQ.N.M.	.0
ENTITLEMT/DEATH REQ N.MET	.0
ENTITLEMT TO OTHER BENEFTS	.0
EARNINGS SELF-EMPLYMT INCR	.0
WAGE INCORRECT	.0
NOT DISABLD-MEDICAL FACTOR	100.0
DISAB ONSET DATE INCR-MEDF	.0
WAIT PERIOD REQ.N.M.-NMEDF	.0
ENGAGED IN ACTIVITY-NMEDF	.0
INCORREC MONTH OF ENTITLMT	.0
DEATH-BENEFT AS TERM EVENT	.0
TRIAL WORK PERIOD INCR EST	.0
REFUSAL TO ACEPT VOC REHAB	.0
WORKMEN'S COMPENSTN OFFSET	.0
MEDICARE (SMI)	.0
COMPUTATN BENEFT AMT INCOR	.0
EARNINGS TEST REQ NOT MET	.0
OTHER	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF	.0
INCOR DETERMINATION-NONMED	.0
INCORRECT DETERMINATION-MED	23.1
INCOR DET MED-NO CONS EXAM	46.2
NO ACTION ON RPT PE CHANGE	.0
INCORRECT ACTION ON PE CHG	.0
INCORRECT APPLICATN-POLICY	.0
NO FOLLOW UP-DIARY CHANGES	7.7
INCOR PROCSSG-ADMIN ACTION	.0
INCORRECT COMPUTATION	.0
INCOR DATA TRANSFER TO SYS	.0
SYSTEMS PROCESSING	.0
INCOMP/INCOR INFO FRM BENE	.0
BENEF FAIL TO REPORT INFO	23.1
PAYMENT ADJUSTMENT LAG	.0
3RD PARTY INCORRECT INFORM	.0
3RD PARTY FAILED TO REPORT	.0
NO ACTION ON 3RD PRTY REPT	.0
INCOR ACT ON 3RD PRTY REPT	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT	.0
PAYMENT TO INELIG	100.0
UNDERPAYMENT	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY	.0
REP PAYEE,LEGAL GRDN	.0
SPOUSE/REL IN HOUSE	.0
OTHER REL,FRIEND,NGH	.0
LANDLORD	.0
FINANCIAL INST	.0
EMPLOYER(PRES/PAST)	.0
SSA RECORDS	30.8
PUBLIC PENS/BENE PRG	.0
PRIVATE PENSION FUND	.0
STATE/LOCAL GOVT REC	.0
OTHER CONTACT	69.2

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE	.0
INITIAL MED ENTITLE	53.8
NMED POST-ENTITLE	.0
MED POST-ENTITLE	30.8
CONTIN DISAB INVEST	.0
RECONSIDERATION	7.7
OTHER PROCESS	7.7
D.O./BRANCH OFFICE	.0
D.O. OFFICE W/PSC RE	.0
PSC(INCLUDES O.D.O.)	7.7
STATE AGENCY	61.5
OFFICE OF SYSTEMS	.0
OFFICE OF INSUR PROG	.0
OFFICE OF DISAB PRGM	.0
OTHER ORGANIZATION	7.7
BENEFICIARY	23.1

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL	100.0
NON-MEDICAL	.0

CATEGORY	PCT. OF DCR CASES
ADMIN	76.9
BENEF	23.1

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	.0	.0	.0
$300.01 - $400.00	.0	.0	.0
$400.01 - $500.00	.0	.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	30.8	30.8	.0
$700.01 & ABOVE	69.2	69.2	.0

```
                                   DI - PROFILES                                        PERCENT OF CASES =      1.6
                                        **                                              CASE ERROR RATE  =     32.7
                                                                                          DOLLAR ERROR RATE
                                                                                            O/P  31.5  U/P       .0
PROFILE 19                                                                              AVE. DOLLAR ERROR =  20P.09
```

```
                                 PCT. OF
DEFICIENCY TYPE               DEFICIENCIES
---------------               ------------
APPLICATN REQUIRE. NOT MET....     .0
INSURED STATUS REQ NOT MET....     .0
AGE REQUIREMENT NOT MET.......     .0
MARRIAGE TO W/E REQ NT MET....     .0
PARENT RELATNSH REQ NT MET....     .0
CHILD RELATNSH REQ NOT MET....     .0
DIVORCE/ANNUL REQ NOT MET.....     .0
DEPENDENCY REQURMT NOT MET....     .0
SUPPORT REQUIREMT NOT MET.....     .0
CHILD-IN-CARE PROV RQ.N.M.....     .0
MARRIAGE AS TERMINAT EVENT....     .0
SCHOOL ATTENDENCE RQ.N.M......     .0
ENTITLEMT/DEATH REQ N.MET.....     .0
ENTITLEMT TO OTHER BENEFTS....     .0
EARNINGS SELF-EMPLYMT INCR....     .0
WAGE INCORRECT................    7.7
NOT DISABLD-MEDICAL FACTOR....   88.5
DISAB ONSET DATE INCR-MEDF....     .0
WAIT PERIOD REQ.N.M.-NMEDF....     .0
ENGAGED IN ACTIVITY-NMEDF.....     .0
INCORREC MONTH OF ENTITLMT....     .0
DEATH-BENEFY AS TERM EVENT....     .0
TRIAL WORK PERIOD INCR EST....     .0
REFUSAL TO ACEPT VOC REHAB....     .0
WORKMEN'S COMPENSTN OFFSET....     .0
MEDICARE (SMI)................     .0
COMPUTATN BENEFT AMT INCOR....    3.8
EARNINGS TEST REQ NOT MET.....     .0
OTHER.........................     .0
```

```
                                    PCT. OF
DEFICIENCY CAUSE                 DEFICIENCIES
----------------                 ------------
INCOMPLETE DEVELOPMT/VERIF....    7.7
INCOR DETERMINATION-NONMED....     .0
INCORRECT DETERMINATION-MED...   26.9
INCOP DET MED-NO CONS EXAM....   23.1
NO ACTION ON RPT PE CHANGE....     .0
INCORRECT ACTION ON PE CHG....     .0
INCORRECT APPLICATN-POLICY....     .0
NO FOLLOW UP-DIARY CHANGES....    3.8
INCOR PROCSSG-ADMIN ACTION....     .0
INCORRECT COMPUTATION.........     .0
INCOR DATA TRANSFER TO SYS....    3.8
SYSTEMS PROCESSING............     .0
INCOMP/INCOR INFO FRM BENE....     .0
BENEF FAIL TO REPORT INFO.....   30.8
PAYMENT ADJUSTMENT LAG........     .0
3RD PARTY INCORRECT INFORM....     .0
3RD PARTY FAILED TO REPORT....     .0
NO ACTION ON 3RD PRTY REPT....     .0
INCOR ACT ON 3RD PRTY REPT....    3.8

                                  PCT. OF
DISCREPANCY EFFECT               DCR CASES
----------- ------               ---------
OVERPAYMENT.....................     .0
PAYMENT TO INELIG...............  100.0
UNDERPAYMENT....................     .0
```

```
DEFICIENCY                  PCT. OF
IDENTIFIER               DEFICIENCIES
----------               ------------
BENEFICIARY.............    15.4
REP PAYEE,LEGAL GRDN....      .0
SPOUSE/REL IN HOUSE.....      .0
OTHER REL,FRIEND,NGH....      .0
LANDLORD................      .0
FINANCIAL INST..........      .0
EMPLOYER(PRES/PAST).....      .0
SSA RECORDS.............    19.2
PUBLIC PENS/BENE PRG....      .0
PRIVATE PENSION FUND....      .0
STATE/LOCAL GOVT REC....      .0
OTHER CONTACT...........    65.4
```

```
                                PCT. OF
DEFICIENCY LOCATION          DEFICIENCIES
-------------------          ------------
INITIAL NMED ENTITLE....        11.5
INITIAL MED ENTITLE.....        11.5
NMED POST-ENTITLE.......          .0
MED POST-ENTITLE........        46.2
CONTIN DISAB INVEST.....         7.7
RECONSIDERATION.........          .0
OTHER PROCESS...........        23.1

D.O./BRANCH OFFICE......         3.8
D.O. OFFICE W/PSC RE....          .0
PSC(INCLUDES O.D.O.)....         7.7
STATE AGENCY............        23.1
OFFICE OF SYSTEMS.......         3.8
OFFICE OF INSUR PROG....          .0
OFFICE OF DISAB PRGM....         3.8
OTHER ORGANIZATION......        26.9
BENEFICIARY.............        30.8
```

```
  PRIMARY DISCREPANCY:
  --------------------
                  PCT. OF
FACTOR          DCR CASES

MEDICAL............100.0
NON-MEDICAL.......     .0

                  PCT. OF
CATEGORY        DCR CASES

ADMIN.............. 70.5
BENEF.............. 29.4
```

```
INCORRECT
PAYMENT AMOUNT         PERCENT OF DISCREPANT CASES:
--------------          ALL DCR.   OP DCR.   UP DCR.
                        --- ----   -- ----   -- ----
$   0.01 - $   4.99        .0         .0        .0
$   5.00 - $  25.00        .0         .0        .0
$  25.01 - $  50.00        .0         .0        .0
$  50.01 - $  75.00        .0         .0        .0
$  75.01 - $100.00         .0         .0        .0
$100.01 - $150.00          .0         .0        .0
$150.01 - $200.00          .0         .0        .0
$200.01 - $300.00          .0         .0        .0
$300.01 - $400.00          .0         .0        .0
$400.01 - $500.00        29.4       29.4        .0
$500.01 - $600.00        23.5       23.5        .0
$600.01 - $700.00          .0         .0        .0
$700.01 & ABOVE          47.1       47.1        .0
```

DI - PROFILES

PERCENT OF CASES = 1.4
CASE ERROR RATE = 44.4
DOLLAR ERROR RATE
O/P 43.0 U/P .0
AVE. DOLLAR ERROR = 311.54

PROFILE 2D

DEFICIENCY TYPE	PCT. OF DEFICIENCIES
APPLICATN REQUIRE. NOT MET....	.0
INSURED STATUS REQ NOT MET....	.0
AGE REQUIREMENT NOT MET........	.0
MARRIAGE TO W/E REQ NT MET....	.0
PARENT RELATNSH REQ NT MET....	.0
CHILD RELATNSH REQ NOT MET....	.0
DIVORCE/ANNUL REQ NOT MET.....	.0
DEPENDENCY REQURMT NOT MET....	.0
SUPPORT REQUIREMT NOT MET.....	.0
CHILD-IN-CARE PROV RQ.N.M.....	.0
MARRIAGE AS TERMINAT EVENT....	.0
SCHOOL ATTENDENCE RQ.N.M......	.0
ENTITLEMT/DEATH REQ N.MET.....	.0
ENTITLEMT TO OTHER BENEFTS....	.0
EARNINGS SELF-EMPLYMT INCR....	.0
WAGE INCORRECT................	.0
NOT DISABLD-MEDICAL FACTOR....	83.3
DISAB ONSET DATE INCR-MEDF....	.0
WAIT PERIOD REQ.N.M.-NMEDF....	.0
ENGAGED IN ACTIVITY-NMEDF.....	.0
INCORREC MONTH OF ENTITLMT....	.0
DEATH-BENEFY AS TERM EVENT....	.0
TRIAL WORK PERIOD INCR EST....	.0
REFUSAL TO ACEPT VOC REHAB....	.0
WORKMEN'S COMPENSTN OFFSET....	.0
MEDICARE (SMI)................	.0
COMPUTATN BENEFT AMT INCOR....	16.7
EARNINGS TEST REQ NOT MET.....	.0
OTHER.........................	.0

DEFICIENCY CAUSE	PCT. OF DEFICIENCIES
INCOMPLETE DEVELOPMT/VERIF....	.0
INCOR DETERMINATION-NONMED....	.0
INCORRECT DETERMINATION-MED...	20.0
INCOR DET MED-NO CONS EXAM....	33.3
NO ACTION ON RPT PE CHANGE....	.0
INCORRECT ACTION ON PE CHG....	.0
INCORRECT APPLICATN-POLICY....	.0
NO FOLLOW UP-DIARY CHANGES....	3.3
INCOR PROCSSG-ADMIN ACTION....	10.0
INCORRECT COMPUTATION.........	.0
INCOR DATA TRANSFER TO SYS....	10.0
SYSTEMS PROCESSING............	10.0
INCOMP/INCOR INFO FRM BENE....	.0
BENEF FAIL TO REPORT INFO.....	6.7
PAYMENT ADJUSTMENT LAG........	.0
3RD PARTY INCORRECT INFORM....	.0
3RD PARTY FAILED TO REPORT....	6.7
NO ACTION ON 3RD PRTY REPT....	.0
INCOR ACT ON 3RD PRTY REPT....	.0

DISCREPANCY EFFECT	PCT. OF DCR CASES
OVERPAYMENT...................	.0
PAYMENT TO INELIG.............	100.0
UNDERPAYMENT..................	.0

DEFICIENCY IDENTIFIER	PCT. OF DEFICIENCIES
BENEFICIARY...............	.0
REP PAYEE,LEGAL GRDN......	.0
SPOUSE/REL IN HOUSE.......	.0
OTHER REL,FRIEND,NGH......	.0
LANDLORD..................	.0
FINANCIAL INST............	.0
EMPLOYER(PRES/PAST).......	.0
SSA RECORDS...............	53.3
PUBLIC PENS/BENE PRG......	.0
PRIVATE PENSION FUND......	.0
STATE/LOCAL GOVT REC......	.0
OTHER CONTACT.............	46.7

DEFICIENCY LOCATION	PCT. OF DEFICIENCIES
INITIAL NMED ENTITLE......	.0
INITIAL MED ENTITLE.......	33.3
NMED POST-ENTITLE.........	16.7
MED POST-ENTITLE..........	26.7
CONTIN DISAB INVEST.......	6.7
RECONSIDERATION...........	3.3
OTHER PROCESS.............	13.3
D.O./BRANCH OFFICE........	.0
D.O. OFFICE W/PSC RE......	.0
PSC(INCLUDES O.D.O.)......	33.3
STATE AGENCY..............	23.3
OFFICE OF SYSTEMS.........	10.0
OFFICE OF INSUR PROG......	.0
OFFICE OF DISAB PRGM......	3.3
OTHER ORGANIZATION........	23.3
BENEFICIARY...............	6.7

PRIMARY DISCREPANCY:

FACTOR	PCT. OF DCR CASES
MEDICAL............	100.0
NON-MEDICAL........	.0

CATEGORY	PCT. OF DCR CASES
ADMIN..............	90.0
BENEF..............	10.0

INCORRECT PAYMENT AMOUNT	PERCENT OF DISCREPANT CASES: ALL DCR.	OP DCR.	UP DCR.
$ 0.01 - $ 4.99	.0	.0	.0
$ 5.00 - $ 25.00	.0	.0	.0
$ 25.01 - $ 50.00	.0	.0	.0
$ 50.01 - $ 75.00	.0	.0	.0
$ 75.01 - $100.00	.0	.0	.0
$100.01 - $150.00	.0	.0	.0
$150.01 - $200.00	.0	.0	.0
$200.01 - $300.00	.0	.0	.0
$300.01 - $400.00	.0	.0	.0
$400.01 - $500.00	5.0	5.0	.0
$500.01 - $600.00	.0	.0	.0
$600.01 - $700.00	40.0	40.0	.0
$700.01 & ABOVE	55.0	55.0	.0

ATTACHMENT 3

Disability Insurance Pilot I Medical Findings

April 1979

I. Review Process

As part of the disability quality review process, all medical entitlement factors were reviewed to determine if the disability status of the beneficiary was correct in the sample month. These reviews were performed in the Quality Assurance Regional Offices by a well trained staff of physicians and disability reviewers. In order to determine the beneficiary's disability status in the sample month, new medical evidence was obtained. If necessary, consultative examinations were purchased.

The physicians, using their medical expertise, were responsible for evaluating the physical and/or mental impairment of the beneficiary according to the appropriate provisions of the Social Security Act and the Regulations. The physicians provide a rating of severity of the impairment and the residual functional capacity (RFC) of the primary beneficiary. The disability reviewers were responsible for interpreting the severity rating and the RFC in conjunction with vocational factors and determining whether the individual was disabled or not disabled in the sample month in accordance with the Regulations. A case analyst was responsible for reviewing the accuracy of payment amounts and any question regarding work activity (substantial gainful activity and/or trial work periods).

The instructions for medical reviewers in Pilot I called for the disability reviewers and the physician to each review the case initially without the benefit of the others' findings. The first review was performed by the disability reviewer. His findings and developmental instructions were then removed from the quality review case file and the case was referred to the physician for his review. The purpose of these independent reviews was to measure the ability of the disability reviewers to recognize the type of new medical evidence needed to make a determination. The results showed that the disability reviewers were more conservative than the physicians, i.e., they tended to request more evidence, which was also more specific in nature, than the physicians. This finding will permit the elimination of the first physician review in future surveys.

In reporting the findings from the medical reviews, sample cases were categorized by the principal body system involved in the beneficiary's impairment. The following tables provide sample payment and case information, including discrepancy rates, for each of these principal body systems. (Note: Medical review findings were not available in all cases, i.e., cases where the beneficiary was deceased. The information in the following tables was derived from the 3,069 sample cases where medical review data forms were completed.) Also included in this section is a table which indicates how the sample cases were distributed based on selected case characteristics. For each grouping the data shown includes the number of cases involved, the percent of the total cases this represents, and the percent of the cases included in the grouping where the beneficiary was determined to be ineligible. A similar table is provided which gives the information only for cases where the primary body system involved in the disability was the musculoskeletal system.

II. Highlights of Findings

- Over 50 percent of the cases involved either the cardio-vascular system (26.7 percent) or the musculoskeletal system (24.9 percent). These cases also contained over 50 percent of the sample payments.
- Over one-third of the excess payments occurred in cases where the principal body system was the musculo-skeletal system.
- Cases involving the hemic and lymphatic system had the highest case discrepancy rate (75 percent) and the highest payment discrepancy rate (71.8 percent). The average dollar error for all cases involving this body system—both correct and incorrect cases—was $309.00 per case. However, only 0.1 percent of all cases involved this body system.
- The second highest case and payment discrepancy rates were observed in cases involving multiple body systems (40.0 percent and 52.9 percent respectively.) All cases with multiple body systems impairments averaged $179.00 in error.
- Cases involving special senses had the lowest case and payment discrepancy rates (8.3 percent and 7.7 percent respectively). These cases had an average dollar error per case reviewed of $25.10.

DI PILOT I

CASE DISCREPANCY RATE

BY BODY SYSTEM

(EXCESS PAYMENTS)

APRIL 1979

PRINCIPAL BODY SYSTEM	SAMPLE CASES		SAMPLE EXCESS PAYMENT CASES		CASE DISCREPANCY RATE
	Number	Percent of Total	Number	Percent of Total	
Cardio-vascular	818	26.7	137	21.6	16.7
Musculo-skeletal	765	24.9	196	31.0	25.6
Mental	449	14.6	68	10.7	15.1
Neurological	228	7.4	43	6.8	18.9
Other (No folder, etc.)	224	7.3	60	9.5	26.8
Respiratory	218	7.1	42	6.6	19.3
Neoplasms	93	3.0	24	3.8	25.8
Special Senses	84	2.8	7	1.1	8.3
Endocrine	79	2.6	19	3.0	24.1
Gastro-intestinal	50	1.6	17	2.7	34.0
Genito-urinary	22	0.7	5	0.8	22.7
Multiple	20	0.7	8	1.3	40.0
Skin	15	0.5	4	0.6	26.7
Hemic and Lymphatic	4	0.1	3	0.5	75.0
TOTAL	3,069	100.0	633	100.0	20.6

DI PILOT I
BODY SYSTEMS RANKED BY
CASE DISCREPANCY RATE
(EXCESS PAYMENTS)
APRIL 1979

PRINCIPAL BODY SYSTEM	CASE DISCREPANCY RATE
Hemic and Lymphatic	75.0%
Multiple	40.0%
Gastro-intestinal	34.0%
Other (No folder, etc.)	26.8%
Skin	26.7%
Neoplasms	25.8%
Musculo-skeletal	25.6%
Endocrine	24.1%
Genito-urinary	22.7%
TOTAL	20.6%
Respiratory	19.3%
Neuorological	18.9%
Cardio-vascular	16.7%
Mental	15.1%
Special Senses	8.3%

DI PILOT I
PAYMENT DISCREPANCY RATE
BY BODY SYSTEM

(EXCESS PAYMENTS)

APRIL 1979

PRINCIPAL BODY SYSTEM	SAMPLE PAYMENTS Amount	SAMPLE PAYMENTS Percent of Total	SAMPLE EXCESS PAYMENTS Amount	SAMPLE EXCESS PAYMENTS Percent of Total	PAYMENT DISCREPANCY RATE
Cardio-vascular	297,588.90	27.9	42,385.10	20.5	14.2
Musculo-skeletal	273,166.20	25.6	69,748.70	33.7	25.5
Mental	137,345.50	12.9	19,734.30	9.6	14.4
Neurological	80,077.50	7.5	14,644.10	7.1	18.3
Other (No folder etc.)	79,254.00	7.4	19,087.40	9.2	24.1
Respiratory	74,317.80	6.9	12,180.50	5.9	16.4
Neoplasms	33,903.10	3.2	8,293.80	4.0	24.5
Special Senses	28,335.60	2.6	2,180.90	1.0	7.7
Endocrine	24,831.60	2.3	5,625.40	2.7	22.7
Gastro-intestinal	16,380.00	1.5	5,700.70	2.8	34.8
Genito-urinary	8,254.30	0.8	1,171.70	0.6	14.2
Multiple	6,786.10	0.6	3,591.30	1.7	52.9
Skin	6,110.00	0.6	1,258.10	0.6	20.6
Hemic and Lymphatic	1,722.00	0.2	1,236.00	0.6	71.8
TOTAL	1,068,072.60	100.0	206,766.00	100.0	19.4

DI PILOT I
BODY SYSTEMS RANKED BY
PAYMENT DISCREPANCY RATE
(EXCESS PAYMENTS)

APRIL 1979

PRINCIPAL BODY SYSTEM	PAYMENT DISCREPANCY RATE
Hemic and lymphatic	71.8%
Multiple	52.9%
Gastro-intestinal	34.8%
Musculo-skeletal	25.5%
Neoplasms	24.5%
Other (No folder, etc.)	24.1%
Endocrine	22.7%
Skin	20.6%
TOTAL	19.4%
Neurological	18.3%
Respiratory	16.4%
Mental	14.4%
Cardio-vascular	14.2%
Genito-urinary	14.2%
Special Senses	7.7%

DI PILOT I
BODY SYSTEMS RANKED BY
AVERAGE DOLLAR ERROR PER CASE
APRIL 1979

PRINCIPAL BODY SYSTEM	AVERAGE DOLLAR ERROR PER CASE
Hemic and Lymphatic	$309.00
Multiple	179.56
Gastro-intestinal	114.01
Musculo-skeletal	91.17
Neoplasms	89.18
Other (No folder, etc.)	85.21
Skin	83.87
Endocrine	71.20
TOTAL	67.37
Neurological	64.22
Respiratory	55.87
Genito-urinary	53.25
Cardio-vascular	51.81
Mental	43.95
Special Senses	25.10

DI PILOT STUDY I

DATA ANALYSIS TOTAL SAMPLE CASES

(N=3069)

CASE CHARACTERISTIC	TOTAL CASES	% TOTAL CASES	% NOT ENTITLED
SEX			
MALE	2089	68.1%	17.2%
FEMALE	971	31.6	21.8
NOT RECORDED	9	0.3	11.1
AGE GROUP			
< 35 YEARS	243	7.9%	19.8%
35-39	105	3.4	23.8
40-49	431	14.0	31.6
50-59	1180	38.5	18.1
60-61	363	11.8	12.4
62-64	700	22.8	13.7
> 64	42	1.4	11.3
NOT RECORDED	5	0.2	60.0
PERIOD OF INITIAL ENTITLEMENT			
5/78-4/79	225	7.3%	10.2%
5/77-4/78	353	11.5	18.1
5/76-4/77	418	13.6	21.5
5/75-4/76	370	12.1	18.1
5/74-4/75	342	11.1	20.5
PRIOR TO 5/74	1353	44.1	18.9
LEVEL OF ALLOWANCE			
INITIAL	2338	76.2%	15.4%
RECON	311	10.1	24.1
ALJ	249	8.1	39.4
AC or DC	16	0.5	31.3
NOT RECORDED	155	5.0	21.3

DI PILOT STUDY I
DATA ANALYSIS
MUSCULO-SKELETAL BODY SYSTEM

TOTAL CASES	765		100%
"ERROR" (ineligible) CASES	184		24.1%
% ALL ERROR CASES		32.2%	

SEX		ELIGIBLE	NOT ELIGIBLE	% NOT ELIGIBLE	TOTAL
MALE		406	117	22.4	523
FEMALE		174	67	27.8	241
NOT RECORDED		1	-	-	1
AGE					
< 35		44	16	26.7	60
35-39		18	7	28.0	25
40-49		69	53	43.4	122
50-59		227	61	21.2	288
60-61		79	10	11.2	89
62-64		135	36	21.1	171
>64		9	1	10.0	10
TIME ON ROLLS					
0-12 MONTHS		40	4	9.1	44
13-24 "		60	20	25.0	80
25-36 "		69	35	33.7	104
37-48 "		74	21	22.1	95
48-60 "		61	25	29.1	86
>60 "		276	78	22.0	354
CE REQUESTED BY DPEQ	YES	228	120	34.5	348
CE REQUESTED BY DPEQ	NO	353	64	15.3	417
LEVEL OF ALLOW.					
INITIAL		444	117	20.9	561
RECON		74	29	28.2	103
ALJ		53	36	40.4	89
AC OR DC		6	2	25.0	8
NOT RECORDED		4	0	0	4

ATTACHMENT 4

Reliability Test

As a part of the empirical testing of procedures and study design factors, a random 40 percent subsample of the 3,069 cases with completed auxiliary data forms were subjected to independent second reviews by physicians and disability reviewers in different regions than those in which the first reviews were done. Each region received cases from each of the other nine regions for second review. All new evidence was available to the second reviewers but not information about the first decision. No additional evidence was developed in the second region. These second reviews (and subsequent third reviews of disagreement cases) constituted the Reliability Test.

The cases were divided into three groups based on the second reviews: 1) both reviews agreed that the primary beneficiary was not disabled in the sample month; 2) the two reviews disagreed as to the disability status in the sample month; and 3) both reviews agreed that the primary beneficiary was disabled in the sample month. In the second group, in some cases the only disagreement concerned the month in which the disability ceased but with different effect on the status in the sample month.

When there was a disagreement about the disability status in the sample month, the case with its new evidence was submitted to the Medical Consultant Staff at CO for an independent third review. In order that the third reviewers would not know whether a case involved a disagreement, some agreement cases were included among the third reviews. When there was a third review, the majority decision was accepted as the "final" decision for the Reliability Test. Following the physician's review, a CO disability examiner also reviewed the case. Some disagreements were only differences in the way the disability examiners interpreted and applied the rules for vocational factors (age, education, work history, transferability of skills etc.).

In the Reliability Test there was an 80 percent agreement rate and a 20 percent disagreement rate. In the resolution of disagreements, decisions went in both directions and thus tended to offset each other to some extent.

Consultation with ORS and a Johns Hopkins clinical psychologist experienced in survey studies provided assurance that under the given conditions a 20 percent level of disagreement was a reasonable one for two independent decisions involving the same evidence when judgment (rather than objective measurement) is necessary in many cases. That level of disagreement, however, underscores the need to seek ways to increase the uniformity of judgments and decisions. Because the purpose of the Reliability Test was to test methods and procedures, the results have been used and will further be used to improve the manual instructions and staff training. They have not been used to revise the results of the first regional reviews as transmitted by the regions to the DI Pilot data base. The Reliability Test did not review non-medical factors or payment amount accuracy.

The findings of the second and third medical-vocational reviews are summarized on the following tables.

DI PILOT STUDY PHASE I

Sample Month - April 1979

RELIABILITY TEST

(A 40% Random Subsample of Cases)

(N= 1172)

	NOT DISABLED	DISABLED	TOTAL
First Review Decisions	276	896	1172
Second Reviews Agree	166	760	926
Agreement Rate	60%	85%	79%

Group I Cases (agreements - Not Disabled)	166	14%
Group II Cases ("problematic" - no agreement)	246	21%
Group III Cases (agreements - Disabled)	760	65%
Total	1172	100%

DI PILOT STUDY PHASE I

Sample Month - April 1979

RELIABILITY TEST

Third Reviews

(N= 398)

FINAL DECISIONS

	Disagreement Cases	Agreement Cases	Total
NOT DIABLED	79	63	142
DISABLED	167	89	256
TOTAL	246	152	398

FINAL RELIABILITY TEST RESULTS

Group I Cases (Not Disabled)	245	20.9%
Group II Cases (Disagreements)	0	0.0
Group III Cases (Disabled)	927	79.1
Total	1172	100.0%

Final DI Pilot I Findings

I. Final DI Pilot I Case and Payment Discrepancy Rates

The table below shows the final case and payment discrepancy rates for the first phase of the DI pilot. These rates were arrived at after a case by case rereview was performed to correct coding errors in the original case findings. The corrections made to the original data caused the case discrepancy rate to increase by 0.1 percentage point while the payment discrepancy rate increased by 0.6 percentage point.

Final DI Pilot I

Case Discrepancy Rates

(Excess Payments)

	Number of Cases	Percent of Cases
Sample Universe (Cases)	3,154	100%
Error Cases	640	20.3%
Medical and Vocational	567	18.0
Non-Medical	73	2.3

Payment Discrepancy Rates

	Amount of Dollars	Percent of Dollars
Sample Universe (Dollars)	$1,100,023	100%
Error Dollars	$ 210,684	19.2
Payments to Ineligibles	205,853	18.7
Overpayments to Eligibles	4,831	0.4

The cases in the pilot where disabilities were questionable have been referred to the appropriate State agencies, which make the initial and continuing disability decisions, for additional medical documentation and development, if necessary, and for determinations. Where it is determined that the person is not disabled, benefit payments will stop. It should be recognized, however, that a person has the right to appeal the decision to terminate benefits. Thus, the cessation rate may be lower than indicated by the error rates from the first phase of the pilot.

II. Second Phase of Pilot Test

SSA has undertaken the second phase of the DI pilot, which is scheduled to be completed during the summer of 1981. The principal differences between the first and second phases are:

- A consultative medical examination is being done on virtually all cases (as compared to less than half the cases in the first phase).
- Physician involvement is delayed until new medical evidence is available (or when medical development is needed) for a determination.
- A second review of all (rather than 40 percent) of the cases will be completed by central office medical staff (rather than regional medical staff).
- The sample is drawn from the DI benefit rolls for July, August, and September 1980, not just a single month as in the first phase.

Data from both phases of the DI pilot and from current CDI efforts will be analyzed and will form the basis for "targeting" corrective action efforts as SSA proceeds with implementation of the Disability Amendments of 1980.

Chairman PICKLE. The hearing is adjourned.

[Whereupon, at 11:30 a.m., the subcommittee adjourned, to reconvene on Wednesday, October 28, 1981.]

SOCIAL SECURITY APPEALS AND CASE REVIEW PROCESS

WEDNESDAY, OCTOBER 28, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, D.C.

The subcommittee met at 10:15 a.m., pursuant to notice, in room H-137, the Capitol, Hon. J. J. Pickle (chairman of the subcommittee) presiding.

Chairman Pickle. The subcommittee will come to order.

We will continue the hearings pertaining to the social security appeal and case review process. Today we have several witnesses, and the Chair has distributed for you a list of these witnesses, and the order in which they will probably be called.

I will depart from it in certain instances for Members of Congress, particularly when Mr. John Seiberling arrives, but otherwise we will try to proceed just as quickly as we can.

There are at least six or seven different groups, and one or two people in a group, so we have a lot of testimony to receive. I am going to ask first that the Association of Administrative Law Judges, Judge Charles Bono, and Judge Ainsworth Brown, to be our first witnesses.

If you would both come to the witness table, we will proceed.

STATEMENT OF CHARLES N. BONO, ADMINISTRATIVE LAW JUDGE, VICE PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Judge Bono. Thank you, Mr. Chairman.

Mr. Chairman, and members of the subcommittee, my name is Charles Bono. I am an administrative law judge with the Office of Hearings and Appeals, and I have been since 1973. I am as well the vice president of the Association of Administrative Law Judges in the Department of Health and Human Services, which consists of approximately 500-member administrative law judges throughout the country.

I am appearing here today with Judge Ainsworth Brown, who sits on my right, as an administrative law judge. Judge Ainsworth Brown is as well an administrative law judge with the Office of Hearings and Appeals, and he is also a member of the board of directors of the association.

We are appearing here today to address you on topics outlined in your committee press release of October 9, 1981. We make this presentation on behalf of the association. We have previously filed with this committee for this hearing here today a written statement of our position consisting of many pages detailing the issues on the agenda, and factors which we feel are important to your considerations.

We respectfully request that that statement be made a part of this record. Understandably, as it is a very lengthy one, both I and Judge Brown will confine our comments here and oral statements here to summaries of what we have presented in the statement.

Chairman PICKLE. Your statement will be made a part of the entire record.

Judge BONO. Thank you, Mr. Chairman.

At the outset, it should be understood that we feel that the Association of Administrative Law Judges, consisting of 500 administrative law judges, which is a majority of the administrative law judges in the Office of Hearings and Appeals, have a very special understanding of the nature of the appeals process with which you have indicated concern, its problems, and the possible solutions to those problems.

The administrative law judges, of course, share the concerns voiced in your press release that the present number of cases pending for hearing before the court has risen to approximately 120,000 in number.

It is often not clear, however, to the judges in the field that the Congress, or the management officials in the Social Security Administration fully appreciate that this caseload has occurred in spite of tremendous work efforts by the administrative law judges in the field, sacrificing their own time in many cases, and in many cases their health, to dispose of more and more cases that are accumulating primarily because of changes in policy of the Social Security Administration with respect to its interpretation of the law as written by Congress.

The association was pleased to learn that the Associate Commissioner in his address to you on October 23, Louis B. Hays, indicated that the administration is not suggesting or proposing hiring outside of the Administrative Procedure Act. In that respect, we had been informed that there was some consideration being given to that initiative to meet the increasing caseload.

If that were to happen, of course, it would be an indication that we were going down the road to abandoning the protections of the Administrative Procedures Act for the appeal system in the Social Security Administration. It is obviously not the solution to the increasing caseload, and would ultimately result in depriving social security claimants of a fair hearing process.

The association would oppose any consideration of a removal of the applicability of the APA to the hearings process in the Office of Hearings and Appeals. Many of the reasons for that opposition are set forth in the statement that we have filed with you, and we hope that the reasons are very clear.

The need to dispose of more cases once before led to serious problems in the appeals process in the Social Security Administration. The need for increased numbers increases the chance that management goals will ultimately collide with the requirements of the fair hearing process.

The recent increase in the caseload and the administration's need to deal with it, and the measures that it has indicated it will take to do so are of vital concern to the many judges in the field.

In the last analysis, they are the judges who have to deal on a day-to-day basis with the real world, meeting on a day-to-day basis with the people who come before them seeking, maybe for the first or maybe the last time in their lives, help from their Government because of ill health or age.

Areas of great concern to the association in recent management initiatives are set forth in the paper we have submitted to this committee.

Chairman PICKLE. Judge Bono, let me interrupt you there. You are reading from a text, do you we have that before us, I can't follow it with any material we have.

Judge BONO. It is a summary, Mr. Chairman. I was under the impression that I was limited to approximately 5 minutes, and it was very difficult. If a written statement is necessary, I have notes.

The Government proposed an anti-APA settlement provision in the *Blankenship* case in Kentucky; proposals have been made to change administrative directives so as to permit management to dictate the minimum number of hearings that a judge should hold in a given period of time; letters have been sent to certain judges in the field telling them that their performance is unacceptable because they have failed to meet certain predetermined criteria in the number of cases they either hear in a given time or decide in a given period; numerical standards of performance have been placed on members of the judges' staff, and the effect will be the enforcement of a quota on the judges and if a quota is not enforced on the judges in that manner, adverse action can be taken against a member of a judge's staff if he does not supply sufficient numbers to his staff to meet that quota certain offices are being given awards on the basis of the number of cases disposed of in a given period; handbook amendments are being proposed by the administration that would adopt the POMS of the State agencies—"Procedural Operations Manuals of the State Agencies"—which amount to guidelines for the State agencies, and would make those guidelines of determination binding on the judges in spite of serious recurring questions as to the legality of those POMS standards or their sufficiency in light of the social security law, the interpretations of the court, as well as the regulations;

Bellmon amendment studies have been implemented that give the appearance, at least, that they are aimed solely at individual judges who do not conform to national statistical averages in their allowances rates, and finally, the representations by the Associate Commissioner to this committee on October 23 that the judges in the field can and have indicated they will be able to do 45 decisions per month, and that such a national average is a reasonable one to obtain.

These initiatives are troublesome to the Association of Administrative Law Judges because they are reminiscent of past management directions employed by past administrations that ultimately culminated in the conclusion being reached in the survey and issue paper of the staff of this subcommittee in Janaury of 1979 that OHA was an agency at war with itself, and that the result of such management initiatives was more emphasis being placed on moving the cases than on providing fair hearings.

A repeat of that all too objectionable part of the appeal system history must be avoided. For that reason, we in the Association of Administrative Law Judges in the past 2 years have continually called the attention of management officials, and now we call the attention of this committee to management initiatives based primarily on numerical solutions which are ill-advised.

Because these problems have recurred, it is obvious that they will continue to occur in a system such as the Social Security Administration, unless some meaningful reforms are pursued to avoid the repeat of mistakes caused by an inordinate increase in the number of appeals.

Without a method to meaningfully enforce the protective provisions of the Administrative Procedures Act to protect the administrative law judges and the Office of Hearings and Appeals, the judges will, as they have been in the past and presently, be left with little effective method of corrective action except to take actions on their own behalf and at their own expense.

The association believes the true answer to the increasing caseload is not in urging the judges to do more and more, but it is to be found in long-overdue systemic changes at the lower levels of the decisionmaking process within the Social Security Administration, the State agency determination levels.

If the lower levels of determination were clearly guided by uniform applications of the social security law, as passed by Congress and as interpreted by the courts, rather than varying policies that increasingly change with fiscal considerations, fairer treatment would be a result at the lower levels, fewer claimants would be dissatisfied with the decisions at the lower levels because they would be made to understand that it is a fairer process at the lower levels. The decisions would be in greater conformity with the written law, and the number of appeals would automatically be reduced.

It must be remembered by this committee that an appeal system only exists for dissatisfied claimants who come to it. It is our position that if the lower levels were more in conformity with the law, there would be less dissatisfaction at the lower levels and fewer appeals. In this manner, this appeals process would receive fewer appeals, and it would no longer be, as it has come to be, a dumping ground for hurried mistakes made at the lower levels of determination.

Pending these needed reforms, it is the recommendation of the Association—again, Mr. Chairman, I hope I am not diverting from my statement in the text, but I am trying to summarize it here as best I can orally—that the APA must continue to control the appeals process in the Office of Hearings and Appeals, and only APA qualified judges should preside over such hearings.

Strong consideration should be given by Congress to the amendment of the Administrative Procedure Act to provide methods of enforcement of its protective provisions, to relieve the judges from being required to time and again take costly measures to insure the continuation of their protection of decisional independence in accordance with the Administrative Procedure Act when infractions occur.

Management initiatives that have the potential of conflicting with Administrative Procedure Act protection must continue to be carefully monitored and avoided to insure meaningful Administrative Procedure Act independence.

We were gratified to hear that the Associate Commissioner has indicated to this committee that he is in favor of continuing with the APA, and to the end of handling the temporary problem of increasing caseload, he intends to hire more judges. We feel that there is no choice in this area; this must be done. More staff must be supplied to those judges to make the hiring of those judges more efficient.

But there is another factor that we must here consider. The status of the appeals process must be elevated in its respect to the lower levels of determination. The exact opposite has been occurring over the year.

Instead of a legal system made up of 500 judges, or 700 judges, who are highly qualified APA appointed individuals controlling what is happening at the lower level, it is the opposite. The lower levels seem to be appearing to try to control what happens at the higher levels of legal interpretation.

At this time, I would like to comment on the social security court bill 3865. It was indicated that comments would be welcomed on that aspect. The Association of Administrative Law Judges, in meeting considered such bill, and while they are in favor of the concept of a social security court, in its present form they oppose it.

Among the major concerns, of course, in its present form, is that the administrative law judge corps, again, is left without consideration, and should a court of appeal system of this nature be established it would be essential that the administrative law judges be made a part of that system and be separate and apart from the Social Security Administration.

In the event a social security court is not established, an ultimate resolution of many of the problems which are revisited each year could be reached if the administrative law judges and the Office of Hearings and Appeals could be removed from management authority of the Social Security Administration to avoid the continuing conflict between the judicial and implementation arms of the Social Security Administration, by placing it either within the Office of the Secretary or under the management of the Office of Personnel Management, which presently controls hiring and qualifying of judges within the Government.

This was a hurried summary of the many things I have in the statement here presented to you. Judge Brown will, in his part of this address, speak to the disparity that exists between the lower levels of determination, and what occurs at the appeals council, and I hope he can give you comments to answer many of the questions you have in that area.

At this time, I will be happy to answer any questions, and I thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF CHARLES N. BONO, ON BEHALF OF THE ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, my name is Charles N. Bono, I am an Administrative Law Judge with the Office of Hearings and Appeals, Social Security Administration, and Vice-President of the Association of Administrative Law Judges in the Department of Health and Human Services.

Accompanying me today is Administrative Law Judge Ainsworth Brown, a member of the Board of Directors of the Association. On behalf of the members of our Association, Judge Brown and I would like to express our appreciation to this Committee for the opportunity it has granted us to present our members' views on the status of the Administrative Appeals process at the hearings level in the Social Security Administration, proposals that have or may be presented which affect the status quo of this process, and the provisions of H.R. 3207 and H.R. 3865.

I shall confine my testimony to the following topics:

(1) The current status of the Hearings Process within the Office of Hearings and Appeals;

(2) The necessity for not only continuing to apply the Administrative Procedure Act to Social Security Hearings, but for strengthening the provisions of the Administrative Procedure Act;

(3) The threat to fair hearings caused by Social Security Administration recent review procedures commenced under the guise of compliance with the Bellmon Amendment; and

(4) Selected comments on H.R. 3865.

Following my presentation, Judge Brown will address the Committee on:

(1) The provisions of H.R. 3207;

(2) The percentage of favorable versus unfavorable determinations at the various administrative levels of determination (Initial, Reconsideration, and Hearing) and reasons for the disparity in these percentages.

I would like to point out to the Committee at this time that our presentation here today is not as complete as we would have wished or as thorough as we believe these important issues deserve. The Association was first informed of this session through your press release on October 9, 1981, and our written testimony had to be filed with the Committee no later than October 27, 1981. In such a short time span, the preparation of a totally thorough and complete position paper, while attending to our normal duties as Administrative Law Judges, was literally impossible. Therefore, so that the Committee will be completely apprised of the Association's position on the matters pending, we will submit a further written presentation which will both supplement and document the facts presented here today upon your specific request.

Our total presentation here today is based upon the propositions that (1) the citizens of the United States, the vast majority of whom are covered by the one title or another of the Social Security Act, have a fundamental right to a fair, impartial, and individualized hearing and decision on the merits of their claims under the Act as passed by the Congress and interpreted by the Courts; (2) that Social Security Administration management initiatives, policies, and regulations have and continue to threaten and/or erode this right; and (3) that swift and sure action must be taken by this Congress to halt and reverse this process, lest the Citizenry lose total confidence in the Social Security program by reason of its failure to provide them with fair treatment of their claims.

1. THE CURRENT STATUS OF THE HEARINGS PROCESS WITHIN THE OFFICE OF HEARINGS AND APPEALS

The claims adjudicated by the Office of Hearings and Appeals consist almost exclusively of appeals from State Agency determinations on the issue of disability. As reported in the Social Security Administration publication "April 1981, Key Workload Indicators" (the latest data available to me), the number of hearing requests increased from in excess of 143,000 in fiscal year 1976, to in excess of 239,000 in fiscal year 1980, with a projected increase in fiscal year 1981 to 259,000. This report clearly indicates that the principal cause of this increase has been, and continues to be, an ever-increasing denial rate of disability claims at both the initial and reconsideration levels of determination. In fiscal year 1976, only 41.6 percent of disability claims were denied at the initial level. At the reconsideration level, in 1976, only 72.3 percent of claims were denied. A progressive increase in the denial rate exists from fiscal year 1976 through fiscal year 1980. In fiscal year 1980, the denial rate at the initial level had risen to 60.4 percent, with the denial rate at the reconsideration level rising to 82.2 percent. This represents an increase of almost 19 percent in the denial rate at the initial level over the five year period, and approximately a ten percent increase at the reconsideration level over the five year period. The projected denial rate for fiscal year 1981 (again the latest report available to me) shows a 60.1 percent denial rate at the initial level and an 83.1 percent denial rate at the reconsideration level. At the same time that the Requests for Hearing have increased over 100,000, and the denial rates have increased substantially (as set forth above), the number of actual claims processed at the initial level has not only remained rather constant, but has actually decreased from a high in fiscal year 1976 of 1,800,000 plus cases, to 1,695,000 plus cases, in fiscal 1980, with the projections for fiscal 1981 being 1,790,000 plus. The corps of Administrative Law Judges, during this same five year period, has remained relatively constant in number. Accordingly, it can be seen from the above statistics alone (which are Social Security Administration statistics), that the dramatic increase in the number of Requests for Hearing and the resulting backlog has been solely caused by ever-increasing denial rates of disability claims at both the initial and reconsideration levels of determination.

What can explain this increase in denial rate which has resulted in the burgeoning backlog which presently exists at the hearing level? Congress has not changed the definition of "disability" under any of the Titles of the Social Security Act during the period from 1975 through the current date, and, accordingly, this cannot explain it. There remain only two other alternative logical explanations of the increase in denial rate. These are:

(1) That the American people have had an astounding decrease in the number of disabling accidents and diseases over the five year period; or

(2) That the Social Security Administration has, by executive fiat and without the formal approval of Congress, changed the criteria for and thereby the definition of "disability."

We believe that a full exploration of the facts will support only the second explanation. In the five year period between 1976 and 1980, the Secretary has changed the substance of key Regulations which, in turn, have changed the definition of "disability." Appendix I, Subpart P, Social Security Administration Regulations No. 4 underwent a total facelift during this period, with the tightening up of medical criteria for a finding of disability on a medical basis alone. Regulations were changed concerning cessation of disability. Previously, the Social Security Administration had to show that the claimant's medical condition had improved to the point where he was capable of engaging in substantial gainful activity before benefits could be terminated. The present Regulation, as interpreted by Social Security Administration policy, provides that a claimant must totally reprove his disability even if the medical evidence shows that his condition has not changed. Other Regulations of major import were enacted to provide that pain alone cannot be considered a disability impairment. This Regulation was enacted despite numerous unappealed precedent court decisions that pain alone can be disabling. Finally, Appendix II, Subpart P, Social Security Administration Regulations No. 4 was added in February 1979. The Secretary is now taking administrative notice of the availability of jobs within the national economy. He is also grouping individuals by age, education and work skills. Previously, the Administration was required in most judicial districts to present vocational expert testimony on the availability of jobs that an individual (not a group) had the capacity to perform. These Regulations attempt to circumvent this court-imposed requirement and allow the Secretary to take administrative notice where the courts had previously stated that Administrative Law Judges could not take administrative notice. The Secretary, in publishing these Regulations and in answer to inquiries concerning these Regulations, stated that this did not represent a change in the adjudication of disability claims; that this procedure had been followed for some time. Subsequently, the Secretary was forced to enter settlements in class action lawsuits which provided for rehearing of denial claims which had been denied under the Regulations which existed prior to the Vocational Rules. This settlement occurred after claimants proved that the Vocational Rules did in fact represent a substantive change in the way disability claims were being adjudicated. The settlement provided for a rehearing of all claims request that had been denied within the four year period preceding the implementation of the Vocational Rules. This in itself added numerous cases to the backlog. Recently some courts are finding the Vocational Rules unacceptable and again requiring vocational testimony (attachment). It is my own personal belief that such decisions will spread and eventually these Rules will be struck down, with the result that all cases denied thereunder will be reheard, further increasing the backlog. The Social Security Administration was warned of this likely non-acceptance of the average man concept by the Department's own lawyers but elected to implement them despite this warning. I know not why. Gentlemen, ask yourselves, are you or were you the same man capable of the same things at 44 that you were at 18? Appendix II says you are.

Further evidence of the increase in the hearing requests, and the resultant increase in the backlog were caused by the increase in the denial rate, comes from the Acting Associate Commissioner for Management, Budget and Personnel, in a January 25, 1980 memorandum, wherein he states: "This situation was precipitated by the increase in the reconsideration denial rate at State Agency level . . . "

This aspect was also very ably dealt with in the report of this subcommittee in its report of March 16, 1981, entitled "Status of the Disability Insurance Program." At page 16 of the report, it indicates that the State Agencies were applying criteria (referred to as policy) that was essentially different from the stated Regulations of the Secretary in determining when cessation of a period of disability could be found. To quote from the report, ". . . no change was made in the Regulations which govern ALJs and, as a result for almost four years these two levels of adjudication were making decisions on the basis of two different rules . . ."

Furthermore, it is important to keep in mind that the only component of the Social Security Administration that has attempted to comply with the court interpretation of the law, as passed by the Congress, has been the Administrative Law Judges. Even though decisions have been issued to the Secretary and, therefore, to all underlying components of the Administration with regard to the use of vocational witnesses, pain, the fact that treating physicians' reports are entitled to greater evidentiary weight, and most recently the unacceptability of the Vocational Rules within the Eighth Circuit, the Social Security Administration's other components have made no attempt to comply with these precedent court decisions. A lawyer learns early in his legal education and his legal career that precedent court decisions are controlling over policy opinion. He learns further that the Constitution controls the law and that the law controls regulations, and that all of the above must control policy. Yet, it has been the Social Security Administration's persistent practice to impose policy which departed from the regulation and regulation which departed from the law. An Administative Law Judge, as a lawyer and an officer of the court, when faced with a confrontation between precedent court decision interpreting the law and regulation or policy not in accord with such court decision, must and can only choose the court decision. On the other hand, the other levels of determination, not being protected by the Administrative Procedure Act and subject to the direct management policy enforcement of the Administration, have not and possibly cannot deviate from the policy even if this policy is illegal. Judge Brown will cover the aspect of the deviance in adjudication methods at the lower levels from the hearing level in more detail.

As can be seen from the above, the major reason for the increase in the number of hearing requests and the resulting backlog is the unjustifiable and unexplainable increase in the denial rates at the initial and reconsideration levels. This increase has not been caused, nor in any way affected, by the fact that the hearing level is an Administrative Procedure Act process comprised of Administrative Law Judges whose independence is protected by the Administrative Procedure Act.

2. THE NECESSITY FOR NOT ONLY CONTINUING TO APPLY THE ADMINISTRATIVE PROCEDURE ACT TO SOCIAL SECURITY HEARINGS, BUT FOR STRENGTHENING THE PROVISIONS OF THE ADMINISTRATIVE PROCEDURE ACT

As the Administrative Procedure Act was designed to afford Administrative Law Judges (formerly hearing examiners) independence in finding facts and rendering decisions free from agency control and influence so that claimants would receive full, fair and impartial hearings in compliance with the Constitutional requirements of due process, any removal of the hearing process in the Social Security Administration from the protection of the Administrative Procedure Act would subvert this decisional independence. In 1977 the importance of the applicability of the Administrative Procedure Act to the decisional independence of Administrative Law Judges was restated in the celebrated case of *Butz* v. *Economou*, U.S. 98 S.Ct. 2894. Previous court decisions such as *Universal Camera Corp.* v. *N.L.R.B.*, 340 U.S. 474, 495 (1951), *Borg Johnson Electronics, Inc.* v. *Christenberry*, 169 F. Supp. 746 (S.D.N.Y. 1959), *Ramspeck* v. *Federal Trial Examiners*, 345 U.S., at 131, all underline the importance of the Administrative Procedure Act to the system of Administrative Law justice in the United States.

Numerous court cases over the years have reiterated the requirement that claimants in Social Security appeals must be given "fair hearings." At various times the removal of the Administrative Procedure Act protection from the hearings process in the matter of Social Security claimants is advanced. The all too obvious motivation for such initiatives has been, and most likely always will be, the need to speed up the system of disposition of cases and dispose of more and more cases in response to an increasing backlog. The need for fair hearings procedures is not reduced by the increase in number of claimants who seek justice. Such initiatives are based upon erroneous assumptions that an increase in number of dispositions is the only answer to the problem. At one time, in the not too remote past, the Administrative Law Judges were threatened with an abandonment of the hearing process unless they would accomplish at least 26 decisions per month. There were those who opposed such quota thinking, but in spite of it all, the Administrative Law Judges in the Office of Hearings and Appeals have increased their disposition rates to nearly 32 per month, and still it has not solved the problem. Can any other solution that only offers the disposition of increased numbers offer a believable solution?

In January of 1979, the staff of the Subcommittee on Social Security concluded in "Survey and Issue Paper," January 27, 1979, 96th Congress, First Session, Committee print WMCP 96-2, that regarding Social Security Administrative Law Judges in the Office of Hearings and Appeals, "emphasis in all phases of the process has been placed on moving the cases rather than rendering fair and sound decisions. Up to now, in OHA's continuing struggle to achieve a balance between quantity and quality, the definite winner has been quantity."

Lawsuits have been filed by various Administrative Law Judges against the officials of the Social Security Administration, alleging improper interference with decisional independence and time and again the Administrative Law Judges have been required to, at their own expense, seek the protection of the courts in resisting management initiatives that seem to ignore the safeguards of the Administrative Procedure Act. These cases were enumerated in the "Survey and Issue Paper" mentioned above. In addition, and since that Survey and Issue Paper was issued, one of those cases was settled between the parties whereby the Social Security Administration agreed essentially to comply with provisions of the Administrative Procedure Act in that they agreed not to set quotas or goals in numbers on Administrative Law Judges' disposition rates, not to publish reversal and affirmation rates of individual Administrative Law Judges, not to dictate to Administrative Law Judges how many cases they should hear or decide in a given period of time, not to base transfer policies or privileges on production quotas, nor assign cases except in true rotation. Since that settlement, there have been numerous reports of continued violations of the provisions of the settlement and of the Administrative Procedure Act, and our Association has undertaken a study that has arrived at the conclusion that consistent violations of the terms agreed to in that settlement have been continuing. It is understandable, therefore, that management officials would perceive the only solution to their problem to be removal of the Administrative Procedure Act safeguards so that they can control the numbers of cases disposed of, the number of cases allowed, and the number of cases denied. It may be a solution to their problem, but it is no solution to the problems of the Social Security claimants who seek, above all, a fair decision, no matter how long it takes, as an unfair one provided hurriedly is no benefit to them.

Further evidence of the continuing problems in the Appeals process which is exerting tremendous pressure on the Administrative Law Judges is presented by the official report of the General Accounting Office issued June 18, 1981 to Senator Max Baucus, a copy of which I am sure has been made available to this Subcommittee, or will be in the near future.

A more recent evidence of continued management pressure to remove the protective provisions of the Administrative Procedure Act from the Administrative Law Judges in the Office of Hearings and Appeals was the filing of proposal of settlement in the case of *Sammie Gail Blankenship, et al.*, v. *Secretary of Health and Human Services*, Civil Action No. C 75 0185 L(A) and in *Georgia Finch, et al.*, v. *Secretary of Health and Human Services*, Civil Action No. C 76-0441 L(A), both filed in the United States District Court for the Western District of Kentucky, at Louisville, which in effect provided for a complete stripping of judicial independence of Administrative Law Judges by means of removing from the Administrative Law Judges the right to determine the development of evidence in particular cases, the time spent in hearing cases, the place of hearings, the length of time taken in deliberation and issuance of a decision, and further provided for punishment of the Administrative Law Judges in the form of sanctions if management orders were not observed in these areas.

The Association of Administrative Law Judges was not advised previously by the Administration that such drastic proposals, which would bear down on the judicial independence of the Administrative Law Judges, were ever under consideration, and when such proposal was filed, the Association had to act in emergency session to authorize retention of counsel and filing of motion to interplead in the case opposing such repeal of Administrative Procedure Act protections of the Administrative

Law Judges in the Department of Health and Human Services. (A position paper prepared by one of our able Judges, Administrative Law Judge Chester Shatz, is here included in part as an attachment hereto, and much of what he has declared in this position paper is nonetheless applicable to any consideration of removal of the Administrative Procedure Act protection.) Although the court in which the case was pending has denied the Association's motion to intervene, it wisely refused to accept such sanctions and far-reaching amendments to the independence of Administrative Law Judges in the Office of Hearings and Appeals.

Still more recently the Social Security Administration has implemented performance standards on all members of an Administrative Law Judge's support staff which set unreasonably high numerical standards for even the minimally satisfactory level of performance.

The Association is on record as opposing any numerical performance standards set by management for attorney advisors. These numerical standards bear no relationship with attorney advisors past performance or total duties, and were designed and implemented without even requesting input from the attorneys or the Administrative Law Judges.

The numerical standards apply only to the number of decisions written and are weighted heavily in favor of denial decisions. No offsetting credit against decisions written is given for the many other integral functions an Administrative Law Judge assigns to attorney advisors, such as analysis of the legal and factual issues in the case before the hearing, legal research, the development of necessary evidence, correspondence with Congressmen and attorneys representing claimants and numerous other duties in the decisional process.

Of particular importance, Social Security Administration management was not even required by the Civil Service Reform Act to design or implement any performance standard for these attorneys. The Association knows of no other attorneys or professionals in the private sector or within government who are subject to numerical quotas such as these. Can you imagine the Veterans Administration telling a surgeon how long he has to perform a difficult operation? This is akin to what management has done to these attorneys.

What reason, therefore, exists for these unique standards? It is arguable that these standards were designed and implemented by management primarily to do indirectly what they know they cannot do directly, i.e., impose a quota on Administrative Law Judges through the quotas imposed on his support staff. The actual effect may be just the opposite, a reduction in overall production due to the inability of the Administrative Law Judge to freely use his attorney advisor as individual case needs dictate.

Unfortunately, no sooner had the *Blankenship* threat been, for the moment, forestalled when we learned of the attempt in appropriations bills recently to suggest and authorize the hiring of non-APA individuals for the purposes of hearing cases involving social security claims. Will non-APA individuals be treated differently than the attorney advisors previously mentioned? The Association believes not.

Many other management initiatives are also on the horizon that will directly interfere with the decisional independence of the Administrative Law Judges and with the quality of justice within the appeals system.

(1) We are reliably informed that contrary to previously stated positions, attorney advisor positions are being replaced with laymen analysts at the same grade, when no logical reason exists for the hiring of less qualified individuals to do this professional work;

(2) Management has initiated proposals that would totally contradict integral parts of the settlement in the Kansas City litigation, i.e., *Charles N. Bono, et al.* v. *United States of America, Social Security Administration, et al.*, Case No. 77-0819-CV-W-4, in the United States District Court for the Western District of Missouri. Western Division, which guaranteed observance of Administrative Procedure Act independence by proposing amendments to administrative directives that would authorize management officials to dictate the number of cases to be heard in a given period of time by Administrative Law Judges;

(3) High level Social Security Administrative officials have issued unfounded public statements criticizing the performance of Administrative Law Judges and their allowance rates which generally degrade the reputation of the appeals process, which is a vital guarantee of due process within the Social Security Administration;

(4) Letters criticizing Administrative Law Judges for the number of cases heard or decided by that Administrative Law Judge have been issued by certain management officials which purport to describe the administrative Law Judge's performance as unacceptable when the agency is specifically prohibited from rating or evaluating the performance of an Administrative Law Judge by the Administrative Procedure Act and Federal Personnel Regulations.

In conclusion of this point, the Association of Administrative Law Judges in the Department of Health and Human Services must register its total opposition to the removal of the applicability of the Administrative Procedure Act from the hearings process in the Social Security Administration, as it will not resolve any of the problems of the backlog, but will instead create a greater appeals docket which will result from a failure to provide fair process to the claimants and resultant appeals to the courts of our land.

It would be the recommended solution that the protection of the Administrative Procedure Act of the hearings process in the Office of Hearings and Appeals be further assured by consideration of this Committee of extensive hearings into methods to provide full observance and acceptance of the provisions of the Administrative Procedure Act to include sanctions or other penalties for violations thereof, or other appropriate measures, against managment officials who violate the Administrative Procedure Act.

In this manner, the corps of Administrative Law Judges would be guaranteed a truly independent position to apply the law of the Social Security Act in accordance with the intent of Congress, and the interpretations of the courts of the land. Should such judicial correction of policy errors of the Social Security Administration be effected by such judicial independence and power, the matters would be self-correcting, fewer appeals would be filed because fairer procedures would be applied at the lower levels, and the crisis now pending would be ultimately resolved.

3. THE THREAT TO FAIR HEARINGS CAUSED BY SOCIAL SECURITY ADMINISTRATION RECENT REVIEW PROCEDURES COMMENCED UNDER THE GUISE OF COMPLIANCE WITH THE BELLMON AMENDMENT

The Commissioner of Social Security has recently announced to the Chairman of this Committee, commencement of the second stage of a two-stage approach of review pursuant to P.L. 96-265, and particularly that portion referred to as the Bellmon Amendment. According to the September 30, 1981 letter from the Commissioner of Social Security to the Hon. Chairman of this Committee, ". . . this review will only include Title II and concurrent disability ALJ reversals and will be conducted prior to the claimant being placed in benefit status. Cases selected for this review will be from ALJs and/or hearing offices that have high reversal rates and will probably include a small random sample of all title II and concurrent disability ALJ reversal cases." (See attachment A).

The Association of Administration Law Judges has and will continue to voice strenuous objection to any method of review or evaluation of an individual Administrative Law Judge based solely on that Judge's allowance or denial rate (the terms "affirmation" and "reversal" are misnomers, as all cases are heard before Administrative Law Judges de novo) as it compares to the national average of allowances or denials for all Administrative Law Judges or whatever other percentage management officials may deem acceptable at the moment.

The danger of such a review on the basis of an acceptable (to management) allowance or denial rate is the coercive effect such review procedures will have on a fair and impartial decisional process for individuals who appear before Administrative Law Judges. An Administrative Law Judge, in hearing and deciding an individual citizen's case, cannot and should not be concerned with his overall allowance rate for the month, the year, or any other specified period of time, or whether such allowance rate compares favorably with what management officials deem acceptable or what Administrative Law Judges are averaging as a body. The sole concern of an Administrative Law Judge, if a fair, impartial, and individualized decision is to be reached on a citizen's claim, must be whether the facts in that individual's case alone justify a favorable or an unfavorable decision under the law, as interpreted by the Courts. The Association and individual members of the Board of Directors of the Association have already received complaints from Judges who feel threatened after being officially notified by management that they have been placed under special scrutiny because of their allowance rates or the allowance rates present in the office in which they serve. An example of the advisory letter sent to one Administrative Law Judge (who asked to remain anonymous) is attached hereto (See attachment B). The Administrative Law Judge Association believes advisory letters such as this, if allowed to continue, can have only a chilling effect on the due process rights of an individual citizen to a fair and impartial hearing under the law.

While each of us, as individual Judges, no doubt believe that we are pillars of integrity who would not consciously compromise the fairness of our decisions as a result of the coercive effect of this and other management initiatives, the fact is that pressures such as this do have an effect on the reasoning processes of a Judge. You should not forget that Judges are only human. They have wives and husbands, children, and financial responsibilities. When an individual Judge perceives a threat to his security (financial or otherwise) it would be naive to think that such a threat will not have an effect on a Judge's mental functioning with a corresponding chilling effect on the rights of those who appear before the Judge. The Administrative Law Judges, in general, perceive that over the past five years they have been under constant and unrelenting management pressure with numerous management initiatives, designed to produce more and more and more decisions. Management appetite in this regard appears to be insatiable. Now, under the guise of mandated review under the Bellmon Amendment, management tastes have become more limited and now the pressures are not simply for more and more and more decisions, but for more and more and more unfavorable decisions. Whether the Administrative Law Judges' perception is an accurate one is not important. The important result is that Administrative Law Judges generally feel they continue to be constantly and continually pressured and threatened and that such pressures have reached the point where it appears the management of the Social Security Administration wants a quick and rubber-stamped signature of approval of past actions from an Administrative Law Judge rather than a fair, reasoned, impartial and just decision on an individual claim.

While the Administrative Law Judge Association agrees that the Bellmon Amendment provides for a percentage review of overall decisions of Administrative Law Judges, we do not believe that it was the intent of the Congress to allow management to use such a review as a coercive tool to force Administrative Law Judges to deny claims which would have otherwise been allowed. We further believe that it was not the intent of Congress to delay claimant's benefits or to limit this review to one segment of Administrative Law Judges which management has selected based upon other motives. We believe that the review should be conducted on a random sampling basis, without regard to Administrative Law Judges' allowance or denial rates, and without a coercive notice of the review being forwarded to the Administrative Law Judge.

The need for such a notice is unclear to the Association of Administrative Law Judges. If the purpose of the study is for the use of Congress and not for the improper use of rating, evaluating, and subsequently disciplining an individual Administrative Law Judge or attempting to effect the Administrative Law Judge's thought processes and thereby alter his allowance rate, such a notice is unnecessary. These advisory announcements must and do give rise to cries of interference with judicial independence which are violative of the Administrative Procedure Act. Regardless of the intent of management, it must be recognized that the appearance of impropriety action in reviewing Administrative Law Judges based on their individual allowance rate is taking place. Whether actual impropriety is taking place, we cannot say.

An additional factor worth mentioning with regard to the studies being conducted under the Bellmon Amendment concerns a preliminary study already completed. The previous Associate Commissioner of the Office of Hearings and Appeals, Andrew Young, indicated, following this study, that a significant deficiency is occurring in what is referred to as "short-form decisions," by reason of the fact that such pre-printed short-form decisions do not comply with the provisions of the Administrative Procedure Act. Despite such an admission, the same Associate Commissioner announced to the Administrative Law Judges that they were to continue to use such short-form decisions even though they were deficient. The justification for this was that conformance with the Administrative Procedure Act by writing longer decisions would cause a decrease in case disposition and that this could not be afforded in view of the increasing case backlog. Once again we have another example of legally mandated due process being sacrificed to management's insatiable appetite for increased numbers of dispositions.

This completed study can have little meaning in a report to Congress except to point out that longer and more informative decisions should be written to insure accuracy, and that management continues to foster a policy which frustrated their purported desire for this accuracy. This is a factor which many Administrative Law Judges, including myself, recognized long before such study was commenced and with such recognition stopped using these improper short forms.

4. H.R. 3865 SHOULD BE AMENDED TO INCLUDE THE ADMINISTRATIVE LAW JUDGE CORPS PRESENTLY IN THE OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, WITHIN THE SOCIAL SECURITY COURT SYSTEM PROPOSED TO BE ESTABLISHED

The Board of Directors of the Association, in its October meeting, approved (by formal resolution) the concept of a Social Security Court. However, the resolution of the Board of Directors provides for its opposition to H.R. 3865 in its present form.

A major concern of Administrative Law Judges with the present form of H.R. 3865, is that it fails to provide for the removal of the present corps of Administrative Law Judges from the management and control of the Social Security Administration. One of the primary and obvious intended purposes of the Social Security Court System Bill is the establishment of a Court from which would flow a uniform body of case law applicable to all levels of adjudication within the Social Security Administration. If the fact finders (the Hearing Judges) are left under the management and control of the Social Security Administration and appeals are to a Social Security Court system, independent of the management and control of the Administration, the disparities which exist between U.S. Circuit and District Court decisions, hearing level decisions, and the initial and reconsideration determinations of the Administration, will continue.

The present lack of uniformity between the various Circuit and District Courts has been cited by proponents of the Social Security Court Bill. However, they fail to discuss true reason for the lack of uniformity. This reason is that the Social Security Administration has most often chosen not to appeal decisions to higher courts so that a uniform body of law could be established. Instead, they have continued to employ policies and procedures which various Circuit and District Courts have said, and continue to say, are not in conformance with the Social Security Act. As a result, a solid and firm body of precedent law has been allowed to build within a judicial circuit or district which varies from one circuit to another. This in turn has placed an Administrative Law Judge in the quandary of being bound by policy which is in direct opposition to a long line of consistent precedent court decisions within the district in which he hears cases and by which, as a practical matter, he should follow. The Administration, rather than appealing these decisions, chooses to "not acquiesce" in those decisions it does not like. We, as lawyers and Judges, do not know what "not acquiesce" means or its role within our system of government which calls for Congress to enact laws, the Courts to interpret the laws, and the executive to implement the laws as interpreted by the Courts. Apparently, the Social Security Administration does not consider itself bound by the precedent decisions of the U.S. District Court when it disagrees with them, or when those decisions are not in accord with the policy which the Social Security Administration seeks to continue.

While technically correct, the Social Security Administration's position that it is bound by an adverse Circuit or District Court decision only in the specific case in which it decides (excepting Supreme Court decisions), and that an Administrative Law Judge should follow the Administration's interpretation of the law even when such an interpretation conflicts with a long line of consistent published precedent court decisions, this position as a practical matter defies rational explanation, is wasteful of the taxpayers' dollars, and is totally ineffective in producing a consistent application of law.

This "pick and choose" policy of the Administration with regard to precedent court decisions is premised on the embodiment of a philosophy of "We don't like it, we won't appeal it, we'll just ignore it."

This policy is not only the principal cause of the disparity in court decisions which now exists, but it also has (1) adversely affected the backlog by forcing judges to needlessly hear the same case a second time; (2) created the Carousel Phenomena which wastes the taxpayer dollars by the needless expense of an Appeals Council action, followed by a District Court action, followed by another Appeals Council action, followed by another hearing, followed by a review of the Recommended Decision by the Appeals Council, all in the face of the Administration having been told many times by the same judicial circuit or district that their policy is unacceptable. The recent case of *Fisher* v. *Schweiker,* 514 F.Supp. 119 (WD.Mo. April, 1981) is a good example of this policy and the problems it creates. In this decision, Judge Sachs finds the so-called "grid regulations" (Vocational rules) unacceptable and states, "Doubtless the district judges in the Eighth Circuit will generally prefer to rely on the directives of our Court of Appeals . . . and will consider it imprudent to rely on the regulations as a substitute for expert testimony. *In order to avoid wasteful and time-consuming rehearings, Social Security Administration personnel* *should take into account evidentiary requirements likely to be imposed in this Circuit."* (Emphasis added)

"My conclusion to reject . . . the theory that the grid regulations avoid the need for expert testimony is bolstered by the generally adverse reaction of other district courts to 'blind reliance' on the regulations by ALJs. . . . As this case shows, people do not easily fit into pigeon holes."

Further, individual Administrative Law Judges faced with such an intransient and impractical policy (while at the same time faced with ever mounting workload) no doubt look for alternatives to side-step the problems this policy presents. It is not management which has to rehear these needless court remand cases, it is the individual Administrative Law Judge, and if he can avoid it and achieve a just result he most likely will. This no doubt contributes to the disparity between the allowances at the hearings level and that at the lower levels. The lower levels blindly follow policy in denying a claim while the Administrative Law Judge innovatively finds a way to allow it the first time he hears it rather than going through time-consuming and wasteful process of allowing it only after a court mandate.

If a new court of special jurisdiction called the Social Security Court comes into being without the Administrative Law Judge hearing system being placed under this court, and outside of the management and control of the Social Security Administration, disparity in interpretation of the Social Security Act and claims filed thereunder will continue since the Hearing Judge will continue to be faced with the quandary of following precedent court decisions of this new court or, alternatively, the conflicting policy of the Social Security Administration when it chooses to "not acquiesce." On the other hand, if the Administrative Law Judge corps is placed in the Social Security Court system and subject to its control and not the control of the Social Security Administration management, and the Administrative Law Judges are given the power to remand cases which are not in accord with the established body of court decisions (Social Security Court), the management of the Social Security Administration will be forced to conform its policies to the law. Once the Social Security Administration is no longer allowed to "not acquiesce" in decisions with which they disagree, the denial/allowance rates at the initial and reconsideration levels will become more realistic and reasonable. Also becoming more realistic and reasonable will be the allowance/denial rate at the hearing level. In turn, over a period of time, less appeals will be filed, not only due to a more balanced allowance/denial rate at the various levels, but also due to the consistent body of precedent decisions established by the Social Security Court system and policies established by management which do not conflict with these precedent court decisions. The question for Congress' consideration is whether policy will continue to control law within the Social Security Administration or whether law, as interpreted by the courts, will control policy.

It should be obvious that the big losers if this "non-acquiesce" policy is allowed to continue are the taxpayers who fund this folly and the claimants (most of whom are already in dire need of funds) are ultimately allowed benefits only after needless and time consuming appeals necessitating the burdensome expense of a lawyer.

A corps of Administrative Law Judges separate and apart from the Social Security Administration has been previously recommended to this Commmittee for consideration in a position paper presented to Mr. Fred Arner in May, 1981. This position paper set forth in more detail the reasons why such an independent corps is necessary to insure constitutionally fair and impartial hearing process for Social Security hearings. A copy of this paper is attached hereto and incorporated by this reference (See attachment A to this Part 4).

CONCLUSION

In conclusion, it is the position of the Administrative Law Judge Association that the appeals process in the Social Security Administration must remain under the protection of the provisions of the Administrative Procedure Act. There is abundant evidence that a fair hearing process cannot long survive, should this protection be removed.

It is no solution to the problem of increasing number of cases to be heard to permit the appointment of non-APA hearing officers, who are less qualified, and would most certainly be totally subject to management interference with their decisional independence. There is no evidence that they could dispose of any more cases than an Administrative Law Judge.

We are not willing to accept the proposition that a non-APA Hearing officer will be able to do more without the safeguards of the Administrative Procedure Act, because he could only do so if he were free to develop the evidence in the case less, hold faster and less thorough hearings, write shorter and less informative decisions, and generally provide less fair hearing procedure if ordered by management officials to do so.

The Association of Administrative Law Judges in the Department of Health and Human Services cannot agree to accept less justice for American citizens because of the need to produce more and more numbers, or because of fiscal budget considerations. There are sufficient qualified candidates who can be hired as Administrative Law Judges, if more judges are needed to handle the increased caseload. It is equally evident that the present appeals system of Administrative Law Judges is increasingly hindered in its mission to provide fair hearings by reason of the fact it is contained within the management realm of the Social Security Administration which has an inherent conflict of interest between its mission of administering the trust fund with all of its attendant fiscal considerations, and its mission to provide a fair and impartial hearing process.

If the Administrative Law Judge corps remains in the Social Security Administration and measures are not taken to remove the consequent administrative pressures on the Administrative Law Judges, which conflicts with their judicial duty to provide fair hearings, the fairness of the appeals process will continue to suffer.

The appeals process, even with the protections of the Administrative Procedure Act, should be separate and apart from the Social Security Administration. This could be accomplished by making the Administrative Law Judge appeal process an integral part of an independent Social Security Court, if one is established as suggested by H.R. 3865 in the future.

Until such a separate Social Security Court is established, immediate partial relief of this problem could be accomplished by effectuation of removal of the appeals process from the Social Security Administration and establishing it as a separate entity under the Office of the Secretary, as previously proposed to this Committee by the Association.

The preferred solution that would provide even greater strengthening of the fairness of the appeals process would be to place such appeals process beyond the control even of the Secretary in a system similar to the proposed Social Security Court which would be truly independent, perhaps as a part of the Office Of Personnel Management, which is now charged with the selection of qualified Administrative Law Judges for placement in the various Administrative Law Judge systems.

Until this is accomplished, we are certain the Administrative Law Judges will continue to do their best to provide fair and impartial hearings, despite the attendant difficulties. This Committee should be aware, however, that this continued friction between Administrative Law Judges attempting to perform their sworn judicial duty and management officials attempting to manage the numbers based on fiscal considerations, is extremely perilous to the fair hearing process.

The following is an excerpt from a position paper of Administrative Law Judge Chester Shatz, submitted to the Association of Administrative Law Judges in connection with the Association's Entry of Appearance in the *Blankenship* case. It is included as it is a worthy statement of justification for continued application of the Administrative Procedure Act to Social Security hearings.

APA Considerations

The first question that must be addressed is the type of hearing contemplated by the Social Security Act under both Title II (disability insurance benefits) and Title XVI (supplemental security income (SSI) benefits), and whether the APA applies to such hearings. The Social Security hearing procedures for Title II cases (Title XVI cases are discussed below) are found in Sections 205(b) and (g) of the Social Security Act (42 U.S.C. 405(b) and (g)) wherein it is provided that the Secretary shall give an applicant a right to a hearing if dissatisfied with the Secretary's initial determinations. The Act provides that if a hearing is held, the Secretary shall, on the basis of evidence adduced at a hearing, affirm, modify or reverse his findings of fact as well as his prior determinations. The Act provides also that such applicant, if dissatisfied with the final decision of the Secretary after a hearing, shall have the right to court review. If court review is requested, the Secretary must file a certified copy of the transcript of the record including evidence upon which the findings and decision complained of are based. The Act provides further that the findings of the Secretary, as to any fact, shall be conclusive if supported by substantial evidence.

The Social Security hearings and appeals procedures, with regard to Title II claims, were established in 1939 and therefore antedates the APA which was enacted in 1946 (hearing procedures re Title XVI postdate the APA and are discussed below). In fact, the Attorney General's committee, which was primarily responsible for the drafting of the APA, used the Social Security Act procedures as a model and considered the APA "largely declaratory" of its provisions (See *Richardson* v. *Per-*

ales, 402 U.S. 389, 409 (1971)). The APA provides that its provisions will be applicable "in every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing" (See 5 U.S.C. 554(a)). It thus seems clear that the APA should be applicable to Title II hearings conducted under the mandates of the Social Security Act, since every decision is rendered on the evidence of record as developed during the hearing stage. The fact that the precise words "on the record" contained in the APA, as set forth above, is not included in the cited hearing provisions of the Social Security Act is of no legal consequence (See *United States* v. *Allegheny-Ludlum Steel Corp.*, 406 U.S. 742, 757, wherein the Supreme Court stated that the precise words "on the record" in the applicable statute providing for a hearing is not required to make the APA applicable. See also *Seacoast Anti Pollution League* v. *Costle*, 572 F.2d 872, 876 (1978), certiorari denied, 99 S.Ct. 94, wherein the Court stated "we reject the position . . . that the precise words 'on the record' must be used to trigger the APA. The Supreme Court has clearly rejected such an extreme reading . . . (cases cited) . . . As the Supreme Court has said 'Determination of questions of (the Administrative Procedure Act's coverage) may well be approached through consideration of its purposes as disclosed by its background.' (cases cited). One of the developments that prompted the APA was . . . 'adjudications which have serious impact on private rights.' (cases cited)."

Although the Supreme Court in *Perales*, *supra*, declined to decide whether the APA was applicable to Social Security disability claims under Title II of the Social Security Act because such determination was not crucial to disposition of the issue before it, the court stated that "the social security administrative procedure does not vary from that prescribed by the APA" *id.* at 409. Moreover, other courts that have had to address that question since the *Perales* decision have held that the APA is applicable to actions taken by the Social Security Administration. See for example *Caswell* v. *Califano*, 583 F.2d 9, 15 (1978) wherein the following is stated in footnote 13:

"The Secretary's claim that the Administrative Procedure Act is not applicable to actions of the Social Security Administration is contrary to both the language of the statute and the case law of this and other circuits. See *Ruiz-Olan* v. *Secretary HEW*, 511 F.2d, 1956, 1058 (1st, Cir. 1972); cf. *Richardson* v. *Perales*, 402 (U.S. 389, 409, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1970)). We reject it."

Other clear and convincing evidence showing that the APA applies to Social Security hearing procedures is the legislative history relating to the APA, and that pertaining to the establishment of the current hearing procedures for cases arising under Title XVI (SSI) of the Social Security Act. With regard to the former, it is interesting to note that after passage of the APA, the Attorney-General was called upon by various government agencies to furnish advice on the meaning of various provisions of the APA, since his office has been instrumental in getting the APA passed by the Congress. As a result of receipt of many inquiries from government agencies, he decided to prepare a general analysis of the provisions of the APA, and he did so in a manual entitled "Attorney General's Manual on the Administrative Procedure Act" which was published in 1947 (See introduction to the manual re purpose of its publication attached at the end of this paper), and which often has been cited by the Courts in interpreting APA provisions. On page 15 of that manual, the Attorney General states that adjudication provisions of the APA (5 USC 554) were intended to include such proceedings as "the determination of claims for money, such as compensation claims under the Longshoremen's and Harbor Workers' Compensation Act, *and under Title II (OLd Age and Survivor's Insurance) of the Social Security Act.*" (emphasis added)

In addition to the above, certain legislative history relating to Social Security hearing procedures clearly indicate that it as been the intent of Congress to have Social Security hearing procedures subject to the APA. In this regard, it is important to note the legislative history of P.L. 94-202 which was enacted in 1976 after the *Perales* decision, and which, in part, provided that hearing procedures for Title XVI cases be the same as under Title II. The Senate Report (Senate Report 94-550) specifically states that "The Committee (Senate Finance Committee) and the Department of HEW (now HHS) consistently over the years have declared that the language in Title II (and under the provisions of this bill, Title XVI) of the Social Security Act call for 'on-the-record' hearings which invoke the provisions of the Administrative Procedure Act." (See U.S. Code Cong. and Admin. News, 94th Congress, First Session, Volume 2, p. 2352). Thus, from (1) the case law, (2) legislative history of the APA, (3) legislative history relating to Social Security hearing procedures, and (4) the executive Department's longstanding administrative practice, it seems clear that the Social Security hearing procedures for Title II cases are subject to the APA, and require an APA-appointed hearing officer to hear those cases.

With regard to hearing procedures pertaining to Title XVI cases (SSI) under the Social Security Act, it is equally clear from the legislative history of the hearing procedures thereunder, that, from at least 1976, Title XVI hearings have been subject to the APA. In this connection, it is important to note the debate that occurred after Title XVI become law (in 1974) concerning whether hearings under that Title were subject to the APA, and whether an APA administrative law judge (ALJ) appointed under 5 USC 3105 of the APA was required to hear and decide Title XVI cases. After Title XVI was enacted, the Department (i.e. HEW) took the position that APA ALJs were required for Title XVI hearings, and it therefore requested the Civil Service Commission (now OPM) to furnish it ALJs from its register of eligibles, as it had been doing for presiding officers for Title II hearings. The Civil Service Commission, however, took the position that, unlike Title II hearings, Title XVI hearings did not require APA ALJs. That position was premised on (1) the hearing provisions pertaining to Title XVI included in the Social Security Act (Section 1631), wherein it was provided that the Secretary's determination after hearing as to any fact "was final and conclusive and not subject to review by any Court" (therefore no record was required to be made), and (2) specific provisions in said section giving the Secretary the authority to appoint hearing examiners for Title XVI cases without meeting the specific standards prescribed for ALJs appointed pursuant to the APA under 5 U.S.C 3105 (See "Delays in Social Security Appeals—Hearings Before the Subcommittee on Social Security of the Committee on Ways and Means, House of Representatives 94th Congress, First Session" (1975), pages 84 et seq and "Background Material on Social Security Hearings and Appeals" (1975), WMCP: 74-79).

As a result of the debate mentioned above, Congress enacted legislation in 1976 amending the hearing procedures for Title XVI cases (See P.L. 94-202) by providing the same standard of judicial review for Title XVI cases as was previously provided for Title II cases (i.e. the "substantial evidence" test) and making all SSI hearing examiners who were in the employ of HEW temporary ALJs and deemed specifically by the statute as being appointed under 5 U.S.C. 3105. Such temporary status was to extend to 12/31/78. The legislative history shows that these provisions were enacted by Congress for the express purpose of having both Title II and Title XVI hearings presided over by APA ALJs (See U.S. Code Cong. Admin. News, 94 Congress, First Session, Vol. 2, pages 2347, et seq). Thereafter, on 12/20/77, Congress enacted P.L. 94-216, Section 371, removing the Section 3105 (APA) temporary status set forth in P.L. 94-202 for the SSI hearing officers and making those temporary ALJs permanent ALJs having the same status and duties as all other Social Security ALJs who had previously been appointed under 5 U.S.C. 3105 for cases arising under Title II.

From the date of enactment of P.L. 95-216 in 1977, through the present, all ALJs attached to the Social Security Administration (in the Department of HHS), including former SSI hearing officers, have had authority to hear both Title II and Title XVI cases. Moreover, the Civil Service Commission (now OPM) has, on request from the Department, furnished ALJs to the Social Security Administration from its register of eligibles to hear and decide cases arising under both Title II and Title XVI.

From the above, and in summary thereof, it seems clear from the legislative history, that Title XVI cases are subject to the APA and require APA ALJs as presiding officers. Moreover, as indicated previously, Title II cases are also subject to the APA and require APA ALJs as hearing officers.

PROPOSED USE OF NON-APA HEARING OFFICERS

One of the sanctions proposed by the government is use of non-APA hearing officers to hear both Title II and Title XVI cases. In this regard the government proposes that claimants be given the opportunity for a speedier decision by waiving his or her right to a hearing before an ALJ, and electing instead to have a hearing conducted by an attorney employed by the Social Security Administration. For reasons discussed below that proposal should not be adopted.

In the first place, it is extremely doubtful that the agency can legally permit having hearings presided over by non-APA hearing officers since, as stated above, the legislative intent has been, since at least 1976, that Social Security hearings under both Title II and Title XVI be presided over by APA ALJs, and further that such hearings are to be subject to the APA. Thus, it seems apparent that the agency has no statutory authority to permit hearings being held by non-APA hearing officers. Furthermore, the legislative history mentioned above pertaining to Social Security hearing procedures clearly indicates that Congress intended that only APA

ALJs would hear and decide cases arising under Titles II and XVI of the Social Security Act.

It must be remembered that the Office of Personnel Management (OPM, formerly Civil Service Commission) has since 1977 conceded that both Title II and Title XVI cases must be heard by APA ALJs, and that since that time it has always stood ready to furnish ALJs for that purpose from its register of eligibles. (In fact, recently during December, 1980, the agency did request a list of ALJ eligibles and was furnished same by OPM. From that list approximately 25 were selected by the agency and commitment letters sent to those eligibles.) Thereafter, during January 1981, the new administration cancelled the commitment letters and chose not to hire any additional APA ALJs). Thus, circumstances in the current controversy are not that OPM refuses to furnish ALJs but rather that the agency does not desire to hire more APA ALJs as required by law, and instead seeks by administrative fiat to expand its corps of hearing officers by implementing a hearing procedure neither authorized nor permitted by statute (either under the Social Security Act of the APA).

Implementation of such a procedure would violate provisions of the APA set forth in both 5 U.S.C. 556 and 5 U.S.C. 3105. Those sections of the APA have been interpreted by the courts over several years since the passage of the APA, and the case law clearly indicates that an administrative hearing conducted by an unauthorized officer is invalid (see for example, *Wong Yang Sung* v. *McGrath*, 339 U.S. 33 (1950); *Borg Johnson Electronics Inc.* v. *Christenberry*, 169 F. Supp. 746, 752 *et seq.* (1959); *Pickett et al* v. *United States*, 105 F. Supp. 67 (1952)). It is important to note that in considering this long history of Court interpretation, Congress has not indicated that such an interpretation of the APA is incorrect since it has not taken any action to amend the APA to set forth a different intent. Thus the government's proposal to use non-APA hearing officers is legally invalid and would violate the APA and applicable case law. (Other serious legal questions arise pertaining to the Government's proposal to use non-APA hearing officers. For example, where is the authority for the agency to insure speedier dispostions to those claimants under the proposed procedure at the expense of those who merely seek their statutory rights to a hearing before an APA ALJ? Also, if the incentive for speedier disposition by way of a non-APA hearing officer is proper, would it not also be proper for the agency to promise and insure a speedier disposition to those claimants who agree to waive their statutory right to judicial review?)

Since the case law pertaining to the APA as well as the recent legislative action pertaining to the Social Security Act make it clear that an APA ALJ is required for hearing under Titles II and XVI of the Social Security Act, the question arises as to the consequences that might follow if a non-APA hearing officer is permitted by the agency to hear (and/or decide) Title II or Title XVI cases. It is not difficult to imagine that, assuming the proposal to use non-APA hearing officers is adopted, all cases decided adversely claimants under that hearing procedure might be ordered by a Court (under a class action suit) at some future date to be illegal and violative of both the Social Security Act and the APA. In that likely event, it is easy to predict that such a Court would order all such cases to be reheard because of the legal invalidity of the hearing procedure used. Thus, the procedure being proposed is self-defeating since (1) it would further delay final resolution of a claimant's case; (2) it would tremendously increase the backlog of cases in the Office of Hearings and Appeals of the Social Security Administration; and (3) it would create an undue administrative burden on the Office of Hearings and Appeals.

Aside from the legal arguments set forth above against adopting the proposal to use non-APA hearing officers, strong policy considerations militate against adoption of such a proposal. In this connection, it must be noted that the Social Security Act provides that claimants be given a hearing on their claims for disability benefits if they so desire (See 42 U.S.C. 405). Hearings are conducted, and decisions rendered, by an Administrative Law Judge who has been duly appointed under the provisions of the Administrative Procedure Act. This insures that a claimant's case is heard and decided by an impartial trier of fact who is not subject to agency control. Thus, hearings and decisions by ALJs comport with due process concepts since "due process" requires a hearing before an impartial trier of fact (See *Duffield* v. *Charleston Area Medical Center, Inc.*, 503 F.2d 512 (1974)). To permit a hearing before a non-APA hearing officer who is subject to the control, direction, performance ratings, promotions, and discipline by agency supervisors would seriously impinge on a claimant's right to a fair hearing. In fact such a procedure would circumvent the Congressional intent under the Administrative Procedure Act.

In connection with the above, it is important to note the APA discussion as stated in *Nash* v. *Califano*, 613 F.2d 10, 15 (1980):

"As originally enacted in 1946, the Administrative Procedure Act (APA) vested hearing examiners (as ALJs were then called) with a limited independence from the agencies they served. The hearing examiners had previously been on a par with other agency employees, their compensation and promotion dependent upon agency ratings. The expanding scope of agency activity during the 1930s and early 1940s led to increasingly heavy criticism, however, because the hearing examiners can be perceived as mere tools of the agency concerned, *Ramspeck* v. *Trial Examiners Conference,* 345 U.S. 128, 131 (1953). In response, Congress enacted Sec. 1 of the APA, removing control over the hearing examiners' tenure and compensation from the agencies and vesting it, to a large degree, in the Civil Service Commission.

"The APA provides that ALJs 'are entitled to pay prescribed by the Office of Personnel Management independently of agency recommendations or ratings.' 5 U.S.C. Sec. 5372. In addition, section 4301 and its implementing regulation (5 C.F.R. Sec. 930.211) exempts ALJs from the performance ratings prescribed for other civil service employees. ALJ tenure, moreover, is specifically safeguarded by 5 U.S.C. Sec. 554, which provides that ALJs, unlike other civil servants, may not be removed without a formal adjudication.

"*These statutory provisions draw upon the more ancient wisdom grounded in history and contained in Article III, which safeguards federal judicial independence through still more stringent compensation and tenure provisions.* See Kaufman, *Chilling Judicial Independence,* 88 Yale L. J. 681 (1979). The independent judiciary is structurally insulated from the other branches to provide a safe haven for individual liberties in times of crisis. By analogy, *the process of agency adjudication is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency. Butz* v. *Economou,* 438 U.S. 478, 513 (1978).

"It is clear that these provisions confer a qualified right of decisional independence upon ALJs. First recognized by the Supreme Court in *Ramspeck* v. *Trial Examiners Conference,* 345 U.S. 128 (1953), this special status is a creation of statute, rather than the Constitution. And as their role had expanded, the ALJs functional comparability to judges has gained recognition. For example, in *Butz* v. *Economou,* 438 U.S. 478 (1978), the Supreme Court held that ALJs enjoy absolute immunity from liability in damages for actions taken in their quasi-judicial capacity." (Emphasis added).

From the above, it should be obvious that the holding of hearings and the rendering of decisions by non-APA hearing officers would pose a potential threat to the fair and impartial hearing concept because such hearing officers could for example be subjected to both direct and indirect pressures exerted by agency officials in their attempts to increase decisional production at the expense of quality decision-making. Moreover, such hearing officers could also be subjected to agency pressure to increase denial rates (At present, the denial rate nationwide is only about 38 percent at the hearing level. Thus, ALJs are awarding benefits in 62 percent of all cases heard).

The concept that claimants are entitled to procedural and substantive fairness before a hearing officer is inherent and implicit in the statutory and regulatory schemes under the Social Security Act. In this regard, 42 U.S.C. 405(g) and applicable Regulations provide that the findings made after a hearing can only be disturbed by the Agency appellate review board (Appeals Council), or a Court, if not supported by substantial evidence. Thus, for all practical purposes, a decision after a hearing is "final" except if not based on substantial evidence. A necessary corollary of that mandate is that a decision of a Social Security hearing officer is, as a practical matter, accorded much finality on appeal. Hence, it is very important that a decision be reached through a process that is fair to the parties. Thus, if the merits of a claimant's case is largely shielded from judicial review, as is the case with Social Security claims, it is essential that an administrative decision-maker not only be fair, but also not be subject to any agency control, direction, or interference, no matter how subtle. This fact becomes more apparent under the Social Security hearing procedures wherein the hearing is non-adversary in nature and the hearing officer has the ultimate responsibility for insuring that all facts are developed and placed into evidence, and that the record is full and complete. (See *Stock* v. *Weinberger,* 402 F.Supp. 603 (1975); *Smith* v. *Weinberger,* 394 F.Supp. 1002 (1975); *Garrett* v. *Richardson,* 363 F. Supp. 83 (1973); 20 C.F.R. 404.944, and 416, 1444; 45 Fed. Reg. 52078, 52104, August 5, 1980.)

INTRODUCTION

June 11, 1946, the date on which the Administrative Procedure Act was approved by President Truman, is notable in the history of the governmental process. The Act sets a pattern designed to achieve relative uniformity in the administrative machinery of the Federal Government. It effectuates needed reforms in the administrative process and at the same time preserves the effectiveness of the laws which are enforced by the administrative agencies of the Government. The members of the Seventy-Ninth Congress who worked so assiduously on the McCarran-Sumners-Walter bill showed statemanship and wisdom in dealing with the difficult problems thus presented.

The Department of Justice played an active role in the development of the Administrative Procedure Act. In 1938, at a time when there was criticism of Federal administrative agencies, Homer Cummings, as Attorney General, suggested to the late President Roosevelt that the Department of Justice be authorized to conduct a full inquiry into the administrative process. In response to this suggestion, President Roosevelt requested Attorney General Cummings to appoint a committee to make a thorough study of existing administrative procedures and to submit whatever recommendations were deemed advisable. For this purpose the Attorney General appointed a committee of eminent lawyers, jurists, scholars and administrators.

For a period of two years this committee, known as the Attorney General's Committee on Administrative Procedure, devoted itself to the study of the administrative process. Its work culminated in the issuance of 27 monographs on the operations of the more important Government agencies it had investigated, as well as in a Final Report to the President and to the Congress. This Final Report is a landmark in the field of administrative law. In fact, the main origins of the present Administrative Procedure Act may be found in that Report, and in the so-called majority and minority recommendations submitted by the Committee. These recommendations were the subject of extensive hearings held before a subcommittee of the Senate Committee on the Judiciary in 1941.

There was a lull in legislative activities in the field of administrative law during the next few years by reason of the impact of war. But when Congress in 1945 resumed consideration of legislation in this field, the Chairmen of both the Senate and House Committees on the Judiciary called upon this Department for its assistance. The invitation was accepted, and the task was assigned to the Office of the Assistant Solicitor General. For many months the members of that Office assisted in the drafting and revision of the bill (S. 7) which developed into the Administrative Procedure Act.

Finally, in a letter dated October 19, 1945, to the Chairmen of both Committees on the Judiciary, I endorsed S. 7 as revised. I concluded that "The bill appears to offer a hopeful prospect of achieving reasonable uniformity and fairness in administrative procedures without at the same time interfering unduly with the efficient and economical operation of the Government." Sen. Rep. 752, 79th Cong., 1st sess., pp. 37–38. The bill then moved in regular course through both Committees with a few minor modifications (H.R. Rep. 1980, 79th Cong., 2nd sess., p. 57). It was subsequently adopted by both Houses of Congress without a dissenting vote.

After the Administrative Procedure Act was signed by President Truman on June 11, 1946, it became evident that a major phase of our work had just begun. Government agencies were calling upon us for advice on the meaning of various provisions of the Act. We endeavored to furnish that advice promptly and in detail to every agency which consulted us. At length I decided that we could offer a definite service by preparing a general analysis of the provisions of the Act in the light of our experience. This manual is the result of that effort. It does not purport to be exhaustive. It was intended primarily as a guide to the agencies in adjusting their procedures to the requirements of the Act.

George T. Washington, the Assistant Solicitor General, was assigned the tasks I have just described—both the rendition of advice to the agencies and the preparation of the manual. He had assisted in drafting the Act and was familiar with the administrative problems of the agencies. Two members of his staff, Robert Ginnane and David Reich, took the major burden of the work, under the supervision and direction of Mr. Washington and myself. The manner in which the task has been carried out has my full approval.

While the manual was intended originally for distribution only to Government agencies, public demand for it has been so great that I have decided to make it generally available. I trust that it will prove helpful to those who find a need for it.

A word of explanation as to the manner in which the manual is arranged should be helpful. It has been prepared mainly on a section by section analysis of the Act. Each of the major sections is treated in a separate chapter. There has been no separate treatment of section 11, covering the appointment of examiners, since the Civil Service Commission is entrusted with the responsibilities under that section and is presently engaged in working out the necessary requirements, assisted by an

Advisory Committee of experts designated by the Commission. No chapter as such is being devoted to either section 2 (definitions) or to section 12 (construction and effect) for the reason that by themselves they have little meaning except in connection with the functional aspects of the Act. However, there is a separate chapter on two important phases of section 2, namely, the coverage of the Act and the fundamental distinction between rule making and adjudication.

TOM C. CLARK,
Attorney General.

August 27, 1947.

THE COMMISSIONER OF SOCIAL SECURITY,
Baltimore, Md., September 30, 1981.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security,
Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am responding to that part of your inquiry of August 14, 1981 concerning the implementation of own-motion review of administrative law judge (ALJ) reversals in Social Security disability cases.

We took a two stage approach to implementing the review of ALJ decisions mandated by P.L. 96-265. The first stage involved a review of approximately 3600 cases to determine the basis for the decision, the effects of personal appearance and additional evidence, and the extent to which different standards are being applied. The results of that review are currently being analyzed by our Office of Research and Statistics. The data from the review will be used to provide a report to Congress as required by the legislation and will be helpful in shaping the ongoing review.

The second state involves a review which will begin October 1, 1981. Unlike the first stage, this review will only include title II and concurrent disability ALJ reversals and will be conducted prior to the claimant being placed in benefit status. Cases selected for this review will be from ALJs and/or hearing offices that have high reversal rates and will probably include a small random sample of all title II and concurrent disability ALJ reversal cases.

On August 17, 1981, we began a test of this stage and are reviewing cases from one hearing office. We are planning to start with a sample of about eight percent. The sample will almost double in the third quarter of the fiscal year as more analytical staff become available in the Office of Hearings and Appeals. In addition to this targeted sample, we will continue our random quality review case selection. However, I must point out that with our use of a targeted sample, I am not certain that it would be necessary to review 35 percent of the reversal cases.

The review standard that the Appeals Council will use is that which now governs requests from dissatisfied claimants. That standard as reflected in sections 404.970 and 416.1470 of Social Security Regulation Number 4 and 16 (20 C.F.R. 404.970 and 416.1470) will permit the desired flexibility for the agency to exercise its own motion authority. To provide the necessary uniformity in review, the Office of Hearings and Appeals will assign a specific group of analysts to this task and will designate specific Appeals Council members, on a rotational basis, to assume this review as their primary activity. As the review expands, we may decide to include it in the regular Appeals Council day-to-day activities.

Sincerely,

JOHN A. SVAHN, *Commissioner.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEMORANDUM

Date: September 24, 1981.
From: Chief Administrative Law Judge.
Subject: Ongoing Review Directed by Section 304(g) of Public Law 96-265—ACTION.
To: Administrative Law Judge.

Purpose

As you may know, section 304(g) of P.L. 96-265, the Social Security Amendments of 1980, requires that SSA implement an own motion review of hearing decisions issued under section 221(d) of the Social Security Act. Planning has been going on for quite some time, and we plan to implement the review on October 1, 1981.

We have chosen both hearing offices and individual ALJs. You have been selected for this review. We will be examining your title II and concurrent disability reversal decisions until further notice. Your cases will be considered as expeditiously as possible. We anticipate no significant payment delay in cases which the Appeals Council does not consider on its own motion authority.

The following instructions should be followed by the staff or person responsible for releasing your reversal decisions dated October 1, 1981 and thereafter.

Instructions

These instructions apply only to disability issue reversal cases. If disability was not at issue in the hearing decision, for example, if workmen's compensation offset or entitlement of a dependent child whose entitlement was not contingent on his/her being disabled, etc., was the issue in the decision, that case should not be referred to OHA.

1. Title II and concurrent disability issue partially and fully favorable reversal cases are to be processed in the normal manner through the issuance and mailing of the hearing decision.

2. The case control instructions outlined in the OHA Case Control System Manual for the posting of the HA-670 control card and the SSA-672 coding sheet will be followed in these cases; enter location code 5005 in "CTT" on both the control card and the coding sheet on the 335 action. Location code 5005 will flag the Case Control System that the case has been selected for the own motion review. (Note: In some concurrent cases, a reversal decision may be issued on only one part. Follow the above instruction for both parts).

3. Hearing cassettes are to remain with the claim folder in the cassette envelope. The cassette(s) are to be placed in the title II folder in concurrent cases. (AMSARS procedures now being piloted experimentally in selected locations will not apply in these instances).

4. Routing of title II only cases: A form HA-5051 is to be stapled to the outside of the claim folder directing it to its normal affectuating component. A form HA-505 is to be stapled on top of the route slip to the effectuating component, directing the claim folder to OHA, P.O. Box 1207, Arlington, VA. 22203.

5. Routing of concurrent cases: The two claim folders are to be separated in the normal manner, with appropriate photocopies placed in the SSI folder. Prepare a form HA-5051 directing the SSI folder to the proper effectuating component and staple it to the SSI folder. Also prepare a form HA-5051 for the title II folder, directing it to the proper effectuation component, and staple it to that folder. Use rubber bands to again combine the folders into one folder (please do not staple them) with the title II folder on top. Prepare a route slip, form HA-505, directing the combined folder to OHA, P.O. Box 1207, Arlington, VA. 22203, and staple it on top of the HA-5051 to the effectuating component for the title II file.

6. The person(s) in the office responsible for releasing the folders will complete a HO/ALJ Report (see copy attached) for each group of cases he/she is referring to OHA. Please supplement the enclosed forms with photocopies until you receive a printed supply of forms. The HO/ALJ Report is to be released at the same time the folders are released. The HO/ALJ Report is to be mailed to: OHA, Office of Appraisal, attn: Ms. Elizabeth Bornmann; P.O. Box 1207, Arlington, VA. 22203. The envelope should carry a DO NOT OPEN IN MAILROOM annotation. A list for each set of cases should be mailed at the same time that the cases are mailed.

7. Post decision correspondence is to be handled in accordance with present instructions.

We appreciate your cooperation in assisting us with smooth case flow in this review. Any problems encountered in complying should be referred to Ms. Dixie Burke at FTS 235-1827 or Ms. Paula Harris at FTS 235-1830.

PHILIP T. BROWN.

Enclosures.

ASSOCIATION OF ADMINISTRATIVE LAW JUDGES,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Santa Ana, Calif., May 19, 1981.

Mr. FRED ARNER,
Chief Counsel, Social Security Subcommittee,
House, Ways and Means Committee,
House Office Building, Washington, D.C.

DEAR MR. ARNER: Pursuant to our telephone conversation of a few days ago, I am submitting to you a position paper of the Association of Administrative Law Judges (ALJs) in the Department of Health and Human Services, proposing that ALJs be reassigned from the Social Security Administration to the Office of the Secretary. Such reorganization can be accomplished either by legislation or by agency action . . . the latter is less likely.

It is hoped that in drafting legislation for the creation of a Social Security Court, you will consider the advantages, outlined in the attached paper, of the inclusion of a provision effectuating the proposed reorganization; it certainly makes organizational sense and is consistent with organizational structures in other agencies utilizing ALJs.

Thank you for the opportunity to submit the attached proposal. If additional information is required, please contact me.

Respectfully yours,

PAUL ROSENTHAL,
Administrative Law Judge, President-Elect, Association of Administrative Law Judges in the Department of Health and Human Services.

PROPOSED ORGANIZATIONAL CHANGE IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES: REASSIGNMENT OF ADMINISTRATIVE LAW JUDGES FROM THE SOCIAL SECURITY ADMINISTRATION TO THE OFFICE OF THE SECRETARY

PROPOSAL

The Association of Administrative Law Judges (ALJs) in the Department of Health and Human Services (DHHS) hereby proposes that the Office of Hearings and Appeals (OHA), including the corps of ALJs, be reassigned, either by appropriate legislation or by agency action, from the Social Security Administration (SSA) to the Office of the Secretary, thereby providing the Secretary with an adjudicative body which provides administrative justice on a full range of DHHS programs. This proposed organizational change would be consistent with organizational structures in other agencies utilizing ALJs, i.e., the adjudicating body in other agencies are, essentially, responsible to the head of the agency.

Procedures for adjudicating cases before OHA ALJs would vary with the type of case involved, program requirements, the needs of the public, etc., and would be geared to offering a range of proceedings from due process, adversary, evidentiary hearings, to non-adversary hearings. OHA already furnishes ALJs for a variety of DHHS cases not directly involving SSA, but such temporary assignments require a paper transfer arrangement.

Moreover, the present organizational structure, with OHA as part of SSA, places the ALJs in a position where they are adjudicating SSA cases for the Secretary, but appear to be organizationally controlled by the Commissioner of SSA. SSA has, in the past, been unable, conceptually, to deal with the role of OHA and its decisional independence, resulting in strained relationships, misunderstandings, and, in some instances, lack of cooperation. Further, the increasing caseload in SSA has magnified the conceptual differences between SSA and OHA, the former attempting increased administrative control in meeting program goals, and the latter, for its part, insisting on fair evidentiary hearings.

Clearly, reassignment of OHA to the office of the Secretary would make better organizational sense, will enhance the appearance of justice, promote due process and the quality of justice afforded the individual litigant, and provide for a healthier and more responsive institutional "legal system." The transition would be simple and immediate; it would incur no additional cost to the agency, but, conversely, in the long run, should result in reduced expenditures by permitting a more efficient operation, with more administrative direction from the top.

DISCUSSION

The Social Security "legal System," as noted above, generates a conflict between the ALJs, who decide cases for the programs administered by SSA, and the other components of SSA which process that caseload. This conflict stems from differences in perspective between SSA administrators and the ALJs, who are constrained by law and by practice to decide individual cases under due process of law. The ALJs constitute the only level of SSA where (1) human factors of credibility must be taken into account, (2) where reasonable inferences as opposed to inevitable inferences must be drawn from facts, and (3) where a detailed decision must be justified on a legal basis, with precise reasons provided for the decision.

Disability cases constitute the bulk of the SSA cases heard by ALJs. Determinations of disability, insofar as the state agencies and SSA generally are concerned, consist of applying rigid criteria to factual situations. An individual is "disabled," according to state agencies, only when his impairments meet certain medical criteria contained in the Listings of Impairments, or (less often applied) he meets the requirements of a regulatory medical-vocational "grid." However, the medical criteria provided in the Listings of Impairments and vocational "grid," are neither all encompassing nor precise in application. For example, it is widely known medically that an individual can have severe and disabling back pain and dysfunction without the so-called classic neurological signs described in Paragraph 1.04(C)(2) of the Listings of Impairments. An individual who meets the criteria of Paragraph 1.04(C)(2) would, as a rule, be incapable of performing any work, but the fact that someone does not meet that criteria does not necessarily show that the individual is able to perform work activity. Actual surgeries have shown that an individual may have a severely herniated disc without having had significant sensory or motor loss. Nonetheless, the state agencies will invariably find tht an impairment not fully described by the criteria provided in Paragraph 1.04(C)(2) is not a severe one. Perhaps that finding is justified because the state agencies are not in a position to assess credibility. The ALJ, however, must assess the credibility of pain where the individual has or is believed to have any impairment which can reasonably produce severe symptoms. Another typical example is angina or chest pain. A person may have severely occluded coronary arteries, with resultant severe chest pain, without necessarily meeting the criteria shown in Paragraph 4.00 of the Listings of Impairments. Again, actual surgeries have demonstrated this fact. Obviously, medical science has not yet advanced to the point where it can diagnose with certainty every medical impairment nor clincially demonstrate the existence of every impairment.

Unlike the state agencies, then, the ALJ must infer from the medical reports of record and from testimony whether there is sufficient basis to demonstrate a probability of impairment which can reasonably be expected to produce severe symptoms and, if so, whether, in fact, the individual has severe symptoms which keep him from performing any substantial gainful activity. A state agency decision is appropriate when it is in accord with medical probability. The ALJ, however, must ensure that reasonable inferences are drawn from the known facts, so long as those inferences are medically possible, and must pass upon credibility of symptoms in those myriad situations where impairments are not accompanied by so-called classic signs of impairment and where there are combinations of impairments with cumulative effects not taken into account by the state agencies.

Credibility and the need to draw reasonable, as opposed to inevitable, inferences from facts is also vital in many nondisability situations. For example, a finding of "fault" would be made by the SSA in an overpayment situation where the individual fails to report information to SSA which caused the overpayment. However, the individual may claim that he was incapable of understanding the need to report that information or that he was led to believe by SSA personnel that the information was not necessary or would not generate an overpayment. Assessment of credibility and the need to make reasonable inferences from facts are critically important to such situations and can not be managed properly on a wholly documentary basis. The need for decisional independence from SSA is critical when actions by personnel within SSA may be called into question.

There is a clear need for an initial decision-making level for SSA, which will be cost-effective, in handling thousands of applications by subjecting these applications to fairly rigid criteria for eligibility. Such criteria can be applied by a staff not capable of making sophisticated judgments or inferences, nor able to take the time to assess the relative merits or credibility of various items of information received . . . a sort of "weeding-out" process. It is also obvious that there is a need, in the American tradition, to provide claimants with an opportunity for an evidentiary hearing, meeting the requirements of due process, and permitting the higher level decision-maker to assess credibility and draw reasonable inferences from facts, and requiring him to prepare written justification for his decision, based on the evidence presented at the hearing. This "trial" level must be perceived as independent of SSA in order for its decisions to be accepted by the public as valid, and must be independent, in fact, of institutional bias in order to arrive at valid decisions.

This difference in function between levels of determination not only has the potential for conflict but, in fact, has generated conflict. In a theoretical sense, perhaps that conflict is not inherent in the system; but, just as in the criminal justice system there is conflict between the manner in which policemen and judges perceive criminal justice, so, too, in the social security system. In the criminal justice system, for example, policemen have often perceived their principal function as making arrests of those disobeying laws and have resented judges for enforcing rules pertaining to the validity of the arrest; similarly, in the Social Security system, the other components of the system have come to view their function as one of enforcing the more rigid criteria for entitlement and to resent the inapplicability of the same criteria at a trial level, even though that is prescribed by law.

Charles Dullea, former director of the Office of Administrative Law Judges, Civil Service Commission, testifed in 1975 before the Subcommittee on Social Security: "There has always been a substantial question about the application of this high-level judicial system on the type of cases handled in Social Security." A former Commissioner of the Social Security Administration opposed the change in title from hearing examiner to administrative law judge because it "would add an additional hurdle to hearing examiners' realization that they are government employees." The Administrative Law Section of the American Bar Association in 1971 found that SSA fostered a breakdown "of fair legal process" because it is not really interested in due process of law in any individual case except to the extent that case affects SSA's litigation record or affects the efficiency of the production line. There has been a running attempt to blame ALJs for any hearing backlog, as typified by recent April 1981 reports printed in the Scripps-Howard newspaper chain quoting from confidential executive sources. Logic would indicate that, where there has been a rising denial rate by the state agencies in the face of a rising so-called "reversal" rate on the part of ALJs, as has been the case, the hearing logjam has been artificially created by an unfair and improper denial of cases.

The system of administrative justice is, thus, not a healthy one. Because of the institutional conflict between ALJs and the other components of SSA, the other components continue on their own track, rather than learning from the bulk of ALJ decisions. For example, in harmony with District and Appeal Court decisions, ALJs find alcoholism disabling where alcoholism, as shown by findings and signs, actually prevents the individual from performing substantial gainful activity. The state agencies continue to be instructed and to invariably find that alcoholism is a remediable impairment regardless of the abundance of associated signs of severe illness (e.g., delirium tremens, gastritis, pancreatitis, ataxia, etc.) which permit an inference of uncontrollable alcoholism. In recent years, the denial rate of state agencies has actually increased even though applications have also increased, thus furthering a hearing logjam, even though ALJ productivity has reached unprecedented heights.

The 1979 Subcommittee on Social Security's report on ALJs noted that the problem of insulating OHA from SSA has long been an issue. SSA's hostility to ALJs and to due process, in general, has a long history going back at least a decade, even though any hearing process without independent factfinders and without due process could never be countenanced. If, as found by the Center for Administrative Justice, a disability appeals court is necessary in order to assure substantial independence from "administrative control" and to protect against "institutional and policy bias," then the same reasoning applies with equal strength to justify any independent hearing level since appellate review can never substitute for a fair and independent hearing process. Indeed, the Staff of the Subcommittee on Social Security, in its 1979 report on ALJs, concluded that, in OHA's continuing struggle to achieve a balance between quantity and quality, the definite winner has been quantity, despite the firm commitment since 1939 of the Committee on Ways and Means to procedural due process for social security applicants.

Reassignment of ALJs from SSA to the Secretary would obviously enhance the appearance of justice. It is evident that any litigant will view with suspicion the decision of a trier of facts paid by and identified closely with the party opposing that individual litigant's concerns. Considering the hostility faced by ALJs within SSA; it is clear that reassignment of ALJs would not only enhance the appearance of justice but, in fact, would promote justice. The ALJs are a hard-working, dedicated corps chosen by a competitive process from the best of experienced attorneys. It is a waste of that corps' expertise when the system, rather than learning from that experienced body, is in actual conflict with it. Reassignment of ALJs would also avoid the institutional difficulties of "enforcing" decisions when SSA disagrees with them, as occasionally occurs. The criminal justice system would not be a healthy one if the police were in charge of the courts. Similarly, the Social Security legal system is not a healthy one because of the constant conflict and friction between those who determine cases for SSA and those who do so independent of institutional bias and control.

Mr. PICKLE. We will proceed with the statement of Judge Brown first, and then we will go to questions.

STATEMENT OF AINSWORTH BROWN, ADMINISTRATIVE LAW JUDGE, MEMBER, BOARD OF DIRECTORS, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Judge BROWN. Thank you, Mr. Chairman.

I want to say that I appreciate this opportunity, Mr. Chairman, to present this statement on behalf of the Association.

One of the important sources of tension between the Social Security Administration and the Administrative law judges in recent years is the difference in standards of disability adjudication. Basically, there is a dichotomy between the standards used at initial and reconsideration levels and at the Hearing and Appeals Council levels of administrative consideration.

At initial and reconsideration, manuals and other instructions are used along with the statutes, the regulations, and social security rulings, the principal sources of guidance for the judges and the council. While there is a handbook for the use of the judges and the Appeals Council, the document does not have the same precedential value as the three sources shared among all of the levels of adjudication.

Another contrasting feature is that the Office of Hearings and Appeals, comprising the judge and the Appeals Council, considers in varying degrees the decisions of the U.S. district courts and courts of appeals. Of course, the entire administrative process follows the decisions of the U.S. Supreme Court.

Thus, there are manual issuances and various written instructions which impact significantly on State agencies as they carry out their adjudicative responsibilities which are given scant attention at the hearing level and beyond. There appears to be, to some extent, a body of unwritten information which is understood by adjudicators as to what criteria will be determinative in deciding whether an applicant is disabled. Specifically, there is the extreme reluctance to recognize pain as a factor which may be disabling in consequence. The current content of part 4 of program operations manual systems does not contain instructive material on the issue of pain, as it has been removed. If there is one rule set forth in the history of judicial review of social security disability claims, it is that pain must be considered and rationalized, so that a hearing decision can successfully withstand judicial scrutiny.

One of the great voids in instructional material for state agencies is the lack of interpretative guidance for adjudicators concerning the significance of court decisions. This is a problem which is broader than the issue of pain evaluation, and the decision not to address the issue directly is an important facet in the contrasting standards of disability adjudication.

Aside from the issue of pain, such issues as the evaluation of alcohol addiction and other psychiatric impairments, the evaluaton of medical opinion evidence, and the effect of several impairments on one's residual functional capacity are other issues which are involved in the difference in standards problems.

Administrative law judges must be attuned to prevailing trends emanating from judicial reviews of disability claims. Some of the language which is frequently cited to set forth what the reviewing courts believe to be the criteria to use in disability adjudication comes from the case of *Underwood* v. *Ribicoff*, 298 F.2d 850 and 851, the Fourth Circuit Court of Appeals decision issued in 1962.

That decision is quoted in my written statement, and goes to the effect:

There are four elements of proof to be considered in making a finding of claimant's abililty or inability to engage in amy substantial gainful activity. These are: (1) objective medical facts, which are the clinical findings of treating or examining physicians divorced from their expert judgements or opinions as to the significance of these clinical findings; (2) the diagnoses, and the expert medical opinions of the treating and examing physicians on subsidiary questions of fact; (3) the subjective evidence of pain and disability testified to by the claimant and corroborated by his wife or neighbors; (4) claimant's educational background, work history, and present age.

Following up on one of these elements is a 1978 social security ruling, SSR78-8. This ruling relates to the evaluation of opinion evidence and is honored at the lower adjudicative levels by being essentially ignored. As a result there is a significant area of disparity between the two lower levels of adjudication and the two upper levels. It should be understood that rulings constitute policy pronouncements by the Commissioner of Social Security which are intended to foster uniformity of decision-making. This ruling is completely consonant with the disability regulations. 20 CFR 404.1527 provides "We have to review the medical findings and other evidence that support a physician's statement that you are 'disabled'." Although this version is not as specific as the previous version, it is still sufficient to convey the idea that medical opinion evidence will be evaluated and not ignored or rejected out of hand.

SSR78-8 also contains the general rule that "Assessment of functional capacity should preferably be reported by a physician who has examined the claimant." Although the policy is enunciated that a review physician has the final authority to render an opinion on residual functional capacity, as we call it, RFC, this obviously would not be binding on the de novo adjudication at the hearing level. Here the judge may utilize opinion evidence, if supported from an attending doctor, a consultative examiner, or an impartial medical advisor who may well have vastly susperior professional qualifications to those of the State agency review physicians.

Within the past year a noticeable change has taken place in State agency practice. This concerns an abrupt stop in the practice of obtaining RFC opinions from consulting examiners. In fact, in the case of consultative examinations requested by judges, there was a refusal for a time by the Pennsylvania State agency to allow consultants to render RFC opinion. The State agency insisted that review physicians complete the physical capacities evaluation form, the PCE, based on their interpretation of the consultant's findings. Eventually, after the insistence of the judges, we prevailed in having the examining physician render the assessment which is more in line with the statement contained in SSR78-8, and I have enclosed a copy of it as exhibit 1 to my statement, that is, a copy of the ruling.

The current legislation proposal to make the adjudicative standards of the POMS binding on all adjudicative levels, though intended to address the issue of differing standards, is not capable of contributing significantly to an improvement in the present situation. Part 4 of the manual system is here before me, and I have these two volumes here on the floor which comprise part 4, and as you see, I will show you just one of them, it is a rather thick volume and contains a multitude of instructions. While this is of little moment by itself, it does connote the existence of a wealth of material, and a reasonable study of the document reveals that it contains a variety of instructions, as I have stated. Some are of a procedural nature, pertaining only to the State agency processing techniques. Other instructions relate to development procedures on how to acquire evidence, advice which is ordinarily not required for one trained in the law. Other material is simply related to lists of various addresses. There is no distinct section that is entitled "Adjudicative Standards," so it is difficult to tell precisely what is intended by the reference.

Included in part 4 are certain temporary sheets which are references as T sheets. I call your specific attention to T2152.1 which is reproduced as an enclosure to this statement as exhibit 2. References to reversal rates being too high for certain impairments is in appropriate material to be made binding on hearing adjudication which, as states before, is a de novo evaluation. Also, cautionary language indicating "a restrictive approach" should be applied to back conditions is equally inappropriate.

More emphasis should be placed on introducing guidance into the disability regulations. The reason for this is that although the rulemaking process is cumbersome in nature, the public should be allowed to comment on proposed regulatory changes. This provides an adequate safeguard against arbitrary and factually flawed regulations.

With respect to social security rulings, which do not require a rulemaking process, it must be understood that the rulings generally provide precedent only in the limited context of fact situation contained in the ruling. This is the chief distinction between rulings and regulations which provide broader general guidelines. Particularly in the disability area with the well established tenet of individual treatment of claims, rulings have had a very limited impact. Thus, in dealing with the issue of limiting disparity at the several administrative levels, regulations have a great appeal as a method to consider.

During the meeting of the board of directors of the Association of Administrative Law Judges held in October 1981, a resolution was passed to oppose the use of programs operations manual systems, part 4, as adjudicative standards applicable at all levels of adjudication. There is a considerable question as to the constitutional permissibility of this delegation of authority to an executive agency. Since the manual is subject to fairly frequent change, and argument is possible that the statute is being changed by the agency. If POMS is raised to this level of importance, routine changes could be considered to be changes in substantive law which would not be within the ambit of executive jurisdiction. It would be well to avoid the thicket of judicial review of this issue. As an illustration of this, I am enclosing a copy of a recent decision discussing program policy statements as exhibit 3. Exhibit 4 is another court decision which suggests modification in the nonadversary hearing system. This is another important factor to consider because it provides the opportunity for the Social Security Administration to articulate its policies more forcefully. Currently there is some interest in Office of Hearings and Appeals in reviving an experiment on having the government represented at disability hearings. This is an approach, if properly constituted, which would be worthy of encouragement.

A separate area of consideration listed in the press release concerning this hearing relates to the issue of attorney fees. Without retracing the legislative history of this issue going back to the time before the 25-percent withholding provision was enacted, it is sufficient to state that there are some important public policy factors favoring the authority of judicial control over legal fees. The association's position is expressed in a resolution passed at our recent meeting that administrative law judge jurisdiction over attorney fees should be retained.

A judge is in the best position to evaluate the significance of legal representation in a matter that is favorably considered at the hearing level. This is a basic judicial function and the reasons upon which the concept of fee evaluation were premised still appear to be valid. The most important reason would be to preserve benefits for the claimant's use, except for the payment of a reasonable fee for legal services. To my knowledge, there is no study or information which has been developed which suggests a material change is needed in the current system. Although some judges do not view this function with enthusiasm, this is not seen as a sufficient basis to make a change.

Thank you for your time, Mr. Chairman, and members of the committee. Judge Bono and I are free for questions, if you have any.

[Exhibits attached to the prepared statement follow:]

RESIDUAL FUNCTIONAL CAPACITY

(Previously Published AS PPD-16)

Purpose: To clarify policy for assessing residual functional capacity (RFC) under titles II and XVI and to specify responsibility for the RFC assessment.

Citations (authority): Sections 233(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended, and Regulations No. 4, Subpart P. Section 404.1502(b) and Regulations No 16, Subpart I, Section 416.902(b).

Pertinent history: In June 1957, the Commissioner of Social Security recommended for inclusion in the regulations the consideration of nonmedical (vocational) factors in the disability determination process. Initially, Regulations No. 4, Section 404.1501, published that same year, mentioned vocational factors and such RFC considerations as moving about, hearing, speaking, handling objects, reasoning and understanding. Subsequently, amendments to the regulations incorporated consideration of RFC and vocational factors in Section 404.1502(b); with the inception of the Supplemental Security Income Program, these considerations were also reflected in Regulations No. 16, Section 416.902(b).

Assessment of functional capacity should preferably be reported by a physician who has examined the claimant. When a treatment or examination report is silent with respect to RFC, or the assessment reported is inconsistent with the evidence, the Disability Determination Services (DDS) staff physician generally has provided an assessment on the basis of all the pertinent evidence in file. In some cases, where the medical information is equivocal or for some other reason the RFC is unclear, a work evaluation center has been used to evaluate an individual's capabilities and limitations. However, the policy has not been clear with respect to the responsibility for assessing the RFC in cases where the usual methods prove to be impractical or impossible. As a result, cases have been adjudicated without a complete or well delineated assessment of RFC. Failure to adequately document the file as to RFC enhances the possibility for judgmental errors and may lead to faulty adjudicative conclusions. Moreover, such failure also makes a potentially correct, but incompletely supported, adjudicative conclusion assailable and subject to reversal.

Policy directive statement: An RFC assessment is necessary for any decision based on Regulations 404.1502(b) and 416.902(b) and must be documented to support the adjudicative conclusion. The RFC assessment may be provided by a treating or examining physician, consultative physician, DDS, Claims Review Section (CRS), or Central Office (CO) staff physicians, work evaluation center, or any other source qualified to make medical judgments. However, the responsibility for providing the

RFC assessment that is consistent with the evidence in file rests finally with the DDS staff physician who evaluates the medical evidence in file including the medical opinions of reporting sources. A DDS staff physician may endorse an assessment that has been provided by a medical source. He may, on the other hand, provide an RFC assessment based on the evidence in file when no actual assessment has been provided or when, in his medical judgment, the provided assessment made by another source is inconsistent with the total evidence. Suitable rationale for the DDS physician's position in the latter situation should be noted in the file.

In those unusual cases where the degree of specificity necessary to evaluate a particular individual's RFC, cannot be provided by the physicians involved; i.e., examining, treating and DDS staff physicians, the DDS lay adjudicators should evaluate the evidence in file to determine the individual's capacity to perform job-related activities. In such situations, the disability determination should reflect the considerations as to how the RFC and the specific job-related requirements which the claimant is capable of performing are supportive of the adjudicative conclusion in light of the total evidence.

Documentation: Each disability decision based on Regulations 404.1502(b) or 416.902(b) requires an RFC assessment with respect to those specific physical or mental capacities that are in issue by reason of the individual's allegations or evidence submitted on his behalf. Where an issue does not exist with respect to particular physical or mental capacities, the presumption is that those capacities are not diminished since the claimant has the burden of proving that he is disabled and of raising any issue with respect thereto, either specifically or by way of medical findings submitted on his behalf.

Hence, the RFC assessment need not make findings with respect to capacities not in issue. RFC assessment may be based solely on medical evidence where such evidence includes sufficient objective findings (e.g., signs, symptoms, and laboratory findings) to permit and support judgments, where relevant, about the individual's capacity for (1) work-related functions, such as standing, lifting, carrying, and handling, (which can be translated into functional capacity for sedentary, light, medium, heavy or very heavy work), (2) mental demands, such as making judgments and tolerating job-related stress, and (3) sensory requirements, such as hearing and seeing. On the other hand, where the medical findings in and of themselves are not fully supportive of an adequate assessment of RFC, such additional factors as the claimant's description of his impairment, recorded observations of the claimant, and any other evidence in file may be considered in conjunction with the medical findings in deriving the RFC.

Residual functional capacity assessments that describe an individual's ability to sustain work-related activities in terms of an ordinary work day on a continuous day-to-day basis can be matched to the physical and mental demands of jobs. Such assessments permit conclusions that an individual can perform substantial gainful work. Conversely, where an RFC assessment establishes that the individual does not have the capacity for work-related functions or establishes that he has the capacity for such functions only on an erratic basis, it permits a finding of inability to perform substantial gainful work.

Cross-References: Disability Insurance State Manual 249.2, Disability Insurance Letter III-3.

T2152.1. Evaluation of PD or PB

A. GENERAL

This temporary instruction supplements DI 2152.1., which provides guidelines for the evaluation of presumptive disability (PD) and presumptive blindness (PB). It will be reissued and updated periodically, if necessary, to reflect any changes in PD reversal rates.

B. IMPAIRMENT CATEGORIES WHERE PD DECISIONS SHOULD BE RESTRICTED

1. Mental impairments

Mental impairments account for over 25 percent of all reversals. With the exception of mental retardation (see DI T2152.1.D.), all types of mental conditions contribute to the high reversal rate. The reversal rate is less for mental cases that ultimately result in a diagnosis of psychosis than for those that result in various nonpsychotic diagnosis. The reversal rate for both is high, however, and in view of continuing data showing that it is difficult to predict the severity of mental conditions with the preliminary evidence used for PD decisions, DDS's should drastically reduce the number of PD decisions in this area. PD decisions in mental disorders should be restricted to situations in which there is striking evidence of prolonged severe psychosis or chronic brain syndrome. These situations will be rare, because evidence that is this convincing will usually be sufficient for the formal disability determination.

2. Respiratory diseases

The reversal rate for diseases of the respiratory system is also too high. Ventilatory function studies are crucial to a determination of disability for most respiratory impairments, and it is difficult to predict ventilatory function with other findings. For this reason, PD decisions should not be made in the respiratory impairment category unless there is extremely convincing evidence.

3. Back conditions

A restrictive approach should also be applied to back conditions. The current data on back impairments, shows a reversal rate of approximately 50 percent nationwide. A more detailed analysis, made several years ago, showed that virtually all types of back conditions resulted in high rates of PD reversal. Cases involving traumatic injury to the spinal cord were the only exception. The continuing extremely high reversal rate in this area would indicate that the reversals are still broadly based, rather than being attributable to a particular back condition that is disproportionately raising the reversal rate for the entire category.

C. IMPAIRMENT CATEGORIES WHERE CAUTION SHOULD BE EXERCISED

Prior studies have shown that several impairments have yielded high reversal rates in the past, and current data, though more general, indicate that these impairments are continuing to show a great risk of reversal.

Therefore, the DDS's should be cautious when making a PD decision for the following impairments:

1. Diabetes mellitus;
2. Epilepsy;
3. Essential hypertension;
4. Hypertensive heart disease;
5. Peptic ulcer;
6. Cirrhosis of the liver; and
7. Bone fractures.

D. IMPAIRMENTS WHERE MAXIMUM PD POTENTIAL SHOULD BE USED

Although reduction of the reversal rate may necessitate some reduction in total PD decisions, this can be minimized by DDS's being especially aware of impairments which have consistently proved reliable and by utilizing the maximum PD potential in these areas. Examples of impairements that have resulted in low reversal rates over the years are:

1. Mental deficiency;
2. Neoplasms;
3. Diseases of the central nervous system resulting in paralysis or motor dysfunction; and
4. Chronic renal disease.

The DDS's should also be alert to the district office (DO) PD categories (see DI 2152.6) and make every effort to identify any cases when the impairment falls into any of these categories but was overlooked by the DO.

[¶ 17,774] Manuel Thomas v. Sec. of HHS. U.S. Court of Appeals, First Circuit. No. 81-1156, 9/14/81. Before Coffin, Chief Judge, Campbell and Bownes, Circuit Judges.

Disability—Definition of "sedentary work".—Reg. §§ 404.1567(a) and 416.910(b)[SSI] state in pertinent part: "Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met." Claimant argues that the definition of sedentary work contained in the Administration's "Disability Operational Policy and Procedures Information Digest" requires that a worker have the capacity to remain seated "*most* of the work day" and that, therefore, he is incapable of sedentary work since he must stand briefly every half hour or so. There is, however, substantial evidence to support the finding that claimant has the capacity to remain seated *most* of the day and, therefore, unde the "Digest", the regulations, and the Social Security Act itself there is substantial evidence to support the finding that claimant is capable of sedentary work. The denial of benefits is affirmed. Back reference: ¶ 12,429.235.

Disability determinations—Reliance on SSA "Digest" of internal operational policy and procedures.—Claimant would "refine" the definition of sedentary work as defined in the regulations in light of certain language in a Social Security Administration policy manual, the "Disability Operational Policy and Procedures Information Digest." He contends that the "Digest" definition of sedentary work requires that a worker have the capacity to remain seated most of the day and, since the evidence shows that he must alternate sitting and standing, that the "Digest" precludes a finding that he can perform sedentary work. The court, however, expresses doubt that the "Digest" could, or was intended to, alter or limit the Secretary's regulatory definition of sedentary work as published in the Code of Federal Regulations. At most, the "Digest" might be viewed as a kind of interpretive rule to be read harmoniously with the regulation and as an aid to its interpretation. In any event, under the "Digest" and certainly under the disability regulations and the Social Security Act itself, there is substantial evidence to support the finding the claimant is capable of sedentary work. Back reference: ¶ 12,429.325, 12,433.

New Matters

The judgment of the U.S. District Court, Dist. of Rhode Island, is affirmed.

Stephen M. Rappoport, Steven J. Hirsch, and Slepkow, Slepkow & Rappoport, on brief for appellant. Paul F. Murray, U.S. Atty., and Everett C. Sammartino, Asst. U.S. Atty., on brief for appellee.

Campbell, Circuit Judge: Appellant Manuel Thomas contends that, chiefly due to arthritis of the left knee, he is unable to work, and that he is therefore entitled to disability insurance benefits under the Social Security Act, 42 U.S.C. §§ 301 *et seq.* His initial application for benefits was denied by appellee Secretary of Health and Human Services, who followed the recommendation of the Administrative Law Judge (ALJ) who conducted a hearing on the claim. Thomas then sought review in the district court pursuant to 42 U.S.C. § 405(g), which remanded the case to the Secretary for the taking of new evidence. Once again, a hearing was conducted before an ALJ, who recommended that the claim be denied, and the Secretary accepted this recommendation. Thomas again petitioned the district court, where his case was first considered by a magistrate, who wrote a thoughtful and detailed opinion recommending that the Secretary's denial of benefits be upheld, and then by Judge Pettine, who issued a further comprehensive decision before entering judgment for the Secretary. We affirm.

The Secretary determined that although appellant is unable to perform his past relevant work, he is able to perform sedentary work, and therefore is not disabled. The Social Security Act defines "disability" as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

42 U.S.C. § 416(i)(1)(A); *id.*, § 423(d)(1)(A). The Act further provides that an individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

42 U.S.C. § 423(d)(2)(A). The Secretary has elaborated on these requirements in a detailed set of regulations. The Secretary has classified jobs by their "exertional requirements." "Sedentary work," which is relevant here, is defined as work which entails lifting 10 pounds maximum and occasionally lifting or carrying such articles as dockets (e.g., files), ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

20 C.F.R. § 416.910(b). Once a finding is made that a claimant is able to perform sedentary work, a table is used to determine whether the individual is disabled, based on his age, education and previous work experience. See 20 C.F.R. Part 404,

Subpart P, App. 2 Table 1 ("the Table"); see also 42 U.S.C. § 423(d)(2)(A), *supra*. Under Rules 201.03 and 201.17 of the Table, appellant must be determined to be not disabled, once the finding that he is able to perform sedentary work is accepted.

Appellant's chief contention on appeal[1] is that the Secretary erred in finding him capable of doing sedentary work, that the Table is therefore inapplicable, and he thus is "disabled" within the meaning of the Social Security Act.

The standard of judicial review under 42 U.S.C. § 405(g) is clear: if the Secretary's findings of fact are supported by substantial evidence, they cannot be disturbed. See, *e.g., Richardson* v. *Perales*, 402 U.S. 389 (1971); *Gonzalez* v. *Richardson*, 455 F. 2d 953 (1st Cir. 1972). Here, there was considerable evidence that appellant could perform sedentary work as defined by the Secretary's published regulations. Virtually all of the medical evidence is in accord that he could do light work if he were mostly sitting down and allowed to stand occasionally. A vocational expert testified that there were numerous jobs that appellant could perform given the medical evidence on his condition.

[RELIANCE ON AGENCY "DIGEST"]

The primary thrust of appellant's arugment is not that he cannot perform sedentary work as defined in 20 C.F.R. § 416.910(b). Rather, he would "refine" this definition of sedentary work in light of certain language in a Social Security Administration policy manual, the Disability Operational Policy and Procedures Information Digest ("the Digest"). This gloss, appellant contends, compels the conclusion that he cannot perform sedentary work on the evidence presented. The Digest, No. 79-20 (April 1979), states that, among the "basic concepts to consider" in determining whether an individual is able to perform sedentary work, is that all sedentary jobs would require that a worker have the capacity to remain seated most of the work day. Therefore, an impairment which compels a worker to alternate standing and sitting at frequent and/or regular intervals would preclude his being able to perform sedentary work. [Emphasis in original.]

Appellant argues that the evidence shows he must alternate sitting and standing, and that the Digest therefore precludes a finding that he can perform sedentary work. We disagree.

At the outset, we express doubt that the Digest could, or was intended to, have the effect of altering or limiting the Secretary's regulatory definition of "sedentary work" as published in the Code of Federal Regulations. *See generally* 2 K. Davis, Administrative Law Treatise § 7.5 (2d ed. 1979). Indeed, the discussion in the Digest is prefaced by a notice stating that it "does not supercede existing operational policy or procedure."

At most the Digest might be viewed as a kind of interpretive rule to be read harmoniously with section 416.910(b) as an aid to its interpretation. *Cf. Nason* v. *Kennebec County CETA*, 646 F. 2d 10 (1st Cir. 1981). Taken in this light, the Digest statement appears merely to emphasize what is already inherent in the phrase "sedentary work"—that one whose disability precludes sitting most of the work is not, in fact, adapted to sedentary work. Evidence in the present record indicates, however, that appellant can sit most of the day, so long as he is able to stand briefly every half hour or so. For example, appellant testified that he often remained seated all morning; most of the medical evidence is to the effect that he could have a job where he was "mostly sitting," although he would have to stand up occasionally. We do not read the Digest as excepting this type of activity restriction from the definition of sedentary work. The primary requirement, as stated in the Digest, following the regulation, is that "all sedentary jobs would require that a worker have the capacity to remain seated most of the day." (Emphasis in original.) The clause referring to "an impairment which compels a worker to alternate standing and sitting" does not limit the definition any further than the primary "seated most of the day" requirement. Rather, it simply elucidates the status of persons, who by reason of their need to alternate between periods of standing and sitting, cannot remain seated most of the day,[2] for example, persons who must often interrupt their sitting with standing for significant periods of time, preventing them from reliably attending to work in a seated position.

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[1] Appellant also contends that the Secretary erred in giving weight to the views of a medical advisor, and should have deferred to the opinion of appellant's treating physician. These arguments are without legal merit. See *Rodriguez* v. *Secretary of HHS*, 647 F. 2d 218, 223-24 (1st Cir. 1981). Moreover, even were we to accept these propositions, there is substantial record support for the Secretary's determination that appellant could perform sedentary work.

[2] This is made clear by the place of the clause in the description (see the quotation in full, *supra*). It comes after the primary requirement and is prefaced by the work "therefore," indicating that it simply explains further what is meant by the first requirement, and has no true independent status of its own.

In this case, there is substantial evidence that appellant need only interrupt his sitting with brief periods of standing in order to relieve pain and stiffness in his knee. The evidence is strong that he does "have the capacity to remain seated most of the day." Therefore, even under the Digest, and certainly under the regulations and the Social Security Act itself, there is substantial evidence to support a finding that appellant is able to perform sedentary work. His claim for disability benefits was properly denied.

Affirmed.

[¶17,759] Jose M. Rivera v. Sec. of HEW, U.S. District Court, S. Dist. of New York. No. 77 Civ. 1928 (VLB), 4/11/81. 513 F. Supp. 194 (1981).

Disability--Disabling effect of pain; consideration of objective evidence—"Medically determinable impairment" requirement; "objective" evidence not required.—The ALJ's placement of undue weight on the lack of objective findings to support claimant's allegations of disabling pain provides good cause for remand. Contrary to the Second Circuit's ruling in *Marcus* v. *Califano* (CA-2, 1979), the ALJ apparently rejected the allegations of disabling pain because they were not supported by objective, clinical evidence. Under *Marcus,* a determination of disability may rest on credible subjective evidence of disabling pain unsupported by clinical findings or other objective evidence. Back references: ¶12,429.5615, 12,429.565.

Disability—Inability to perform former work; shifting of burden to Secretary.—The ALJ's findings incorrectly imply that claimant established a *prima facie* case of disability by showing an inability to perform his former work, but that the Secretary rebutted the *prima facie* case by producing evidence of claimant's ability to perform alternate work. The Secretary, however, did not come forward with evidence of specific jobs available to the claimant and thus failed to meet his burden of proof. If claimant's evidence did not establish a *prima facie* case, then there was no need for findings regarding claimant's ability to perform alternate work. If, on the other hand, claimant's evidence did establish a *prima facie* case, then the Secretary was obliged to produce evidence of specific jobs claimant could perform. The matter is remanded. Back reference: ¶12,429.5515.

Rehabilitation services—Trial-work periods—Remand to determine whether vocational rehabilitation work amounted to a period of trial work.—A disability beneficiary is entitled to a nine-month period of trial work during which he may test his ability to work and still be considered disabled. At issue is claimant's attendance for approximately nine months at a vocational rehabilitation program. Although the ALJ clearly considered claimant's attendance in determining that he was no longer disabled, the record does not conclusively establish the period of claimant's attendance at the program and does not indicate whether the ALJ regarded participation in the program as a period of trial work. A remand is therefore ordered. Back reference: ¶12,437.11.

Memorandum Order

I.

Broderick, District Judge: The plaintiff, Jose M. Rivera, brought this action under the Social Security Act ("the Act")[1] to review a final decision of the Secretary of Health, Education and Welfare denying his application for social security disability benefits and for the establishment of a period of disability.[2] After a hearing the administrative law judge held that plaintiff had failed to prove that he was disabled within the meaning of the Act on or before March 31, 1974, the last date on which he met the special earnings requirements for disability insurance coverage. The administrative law judge's decision became that of the Secretary when it was affirmed by the Appeals Council on April 7, 1977. The case is before me on defendant's motion for judgment on the pleadings and plaintiff's cross-motion for judgment on the pleadings, or, in the alternative, for summary judgment.

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[1] The plaintiff is proceeding under Section 205(g) of the Act, 42 U.S.C. § 405(g).

[2] The plaintiff applied for benefits under § 223 of the Act, 42 U.S.C. § 423, and sought the establishment of a period of disability under § 216(i) of the Act, 42 U.S.C. § 416(i).

II.

[LEGAL ERRORS; REMAND]

In light of certain legal errors, discussed below, the Secretary's determination is reversed and the case is remanded for reconsideration and rehearing consistent with this memorandum order.

III.

[BACKGROUND]

Plaintiff is a 41 year old married male Hispanic, with two children.[3] He has a first grade level of education and at the time of the hearing spoke no English. From 1956, when he came to the United States at the age of seventeen, until 1968 he was employed in various unskilled manual jobs that required him to work in a standing position.[4]

In 1968, while lifting a heavy object, plaintiff injured his lower back. He has not worked since, save for one month's employment at a facility for the handicapped in 1972. He did spend nine months, on an intermittent basis, attending a vocational rehabilitation program to qualify for his workmen's compensation payments, but was unable to continue because of dizziness and numbness in his hands.[5]

Plaintiff spends most of his time either lying down to relieve his back condition or sleeping as a result of the effects of medication.

The administrative law judge considered evidence of plaintiff's impairment relating to the period prior to March 31, 1974, when plaintiff last met the special earnings requirement, and the period after that date.

1. *Period prior to March 31, 1974.*

In 1968, after his injury, plaintiff was hospitalized for treatment with weights applied to his legs. He began treatment with Dr. David Graubard, a general surgeon, in 1969 and continued to see him until 1974. As early as February 23, 1971, Dr. Graubard considered plaintiff to have a permanent partial disability On July 13, 1971, at the recommendation of Dr. Graubard, plaintiff underwent a laminectomy for removal of a herniated disc. After surgery, plaintiff's pain abated. Dr. Irving Etkind examined petitioner on November 3, 1971 and found minimal partial disability. He considered plaintiff able to return to work if he avoided heavy lifting, bending and twisting. On December 1, 1971, Dr. Young of the Workmen's Compensation Board reported that claimant had a mild permanent partial disability.

In December 1973, and again on January 7, 1974, plaintiff was taken to the Metropolitan Hospital emergency room complaining of his back. On the latter occasion he was admitted for eleven days. Treatment consisted of pelvic traction, bed rest, and medication for pain. The plaintiff's discharge summary, prepared by Dr. Giovanelli, stated: "Range of motion limited in flexion and lateral bending. The patient has positive straight leg raising sign on the left with slight decrease of the tendon reflexes on the left. There was minimal motor weakness on the left lower extremity with deminished [sic] sensation along the entire left lower extremity." The summary also noted that "[t]he patient was placed in pelvic traction and bed rest and showed remarkable improvement." The diagnosis was low back derangement. Plaintiff's emergency room treatment was to be followed up in the orthopedic clinic, to which plaintiff made three visits.

On January 25, 1974, shortly after plaintiff's release from hospitalization at the Metropolitan Hospital, plaintiff's treating physician, Dr. Graubard, noted on a prescription pad headed by claimant's name that "the above name is still totally disabled." No reasons were given for this conclusion.

2. *Period from March 31, 1974 to date of hearing.*

The Workmen's Compensation Board classified plaintiff as permanently partially disabled on July 23, 1974. On September 9, 1974, after plaintiff visited Metropolitan Hospital's orthopedic clinic, one Dr. F. Baker, his attending physician, reported to the Workmen's Compensation Board that plaintiff was "still unemployable." In 1975, one Dr. Bernard informed the Workmen's Compensation Board that, among other things, plaintiff had restricted motion of the spine in all planes, limped to the left, and his toe and heel walking were unstable on the left. On March 9, 1976, an interviewer for the Department of Health, Education, and Welfare observed that plaintiff was "slow in responding. It seems as if it is difficult for him to talk. He moves a lot in his chair. Opens and closes his hands a lot. Has difficulty in walking . . . walks with a very marked limp."

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[3] At the time that the administrative law judge rendered her decision the claimant was 37 years old.

[4] In his first employment in the United States, he put screws into beach chairs in a Brooklyn factory. He later took a job installing glass. His third job, at the factory where he suffered the injury resulting in his alleged impairment, appears to have been as a packer.

In Puerto Rico, beginning at the age of 12, he "first worked with a gentleman helping him to prepare things for fumigating," then as a candy wrapper and "floor boy" in two candy factories, and later as a machine operator polishing aluminum windows in a factory.

[5] The dates of plaintiff's attendance at this program cannot be conclusively ascertained from the record. See Part VI, *infra*.

Plaintiff continued to be followed up by the Metropolitan Hospital orthopedic clinic. On April 7, 1976 an orthopedist observed that plaintiff had chronic lower back pain with a "strong psychiatric overlay" and was unemployable. On June 10, 1976, plaintiff's motor and sensory responses were found to be intact and he was characterized as "employable."

Plaintiff was again hospitalized at the Metropolitan Hospital for treatment of lower back pain on August 2, 1976. He was treated with medication, placed in traction, and released after fifteen days. The discharge summary indicated his condition was improved,[6] but one week later at a follow-up orthopedic clinic appointment, plaintiff complained of pain.

Plaintiff was examined twice by Dr. Arturo Pena in connection with his complaints of back pain, once in May 1976, and again in October 1976. On the first visit, Dr. Pena found that the range of plaintiff's motion was flexion 40 degrees, hyperextension 35 degrees, lateral bending to right and left 30 degrees, and rotation to left and right 35 degrees. Straight leg raising was positive on the left at 35 degrees. Dr. Pena recommended an EMG study after his initial examination. When he examined plaintiff again in October, plaintiff had not had the EMG test, but his complaint of pain were unchanged. Dr. Pena found no evidence of pathology in X-rays of the lumbo-sacral spine.

Plaintiff complained of hematuria, for which he was treated by the G. U. Clinic at Metropolitan Hospital from May 1976 until September 1976. IVP and right retrograde pyelogram examinations did not indicate any abnormality.

Plaintiff began seeing Dr. Edgardo Glen for psychotherapy in April 1976. On November 16, 1976 Dr. Glen found "anxiety, depression, feelings of suspiciousness very close to paranoia. This condition was exacerbated by his physical complaints which came about as a result of an accident that he sustained at work. His condition is now chronic—".

3. *Post-hearing period.*

Plaintiff has submitted to this court the affidavit of Dr. Asa P. Ruskin in support of plaintiff's cross-motion for summary judgment. Dr. Ruskin, a neurological specialist, first saw plaintiff on January 11, 1971 in a neurological consultation at the request of Dr. Graubard. He saw plaintiff intermittently in follow-up consultations and after an interval of years resumed treatment of petitioner in 1977, and treated him twice in 1978, and twice in 1979.

Dr. Ruskin states that plaintiff was not under steady treatment by him because his office was moved. Plaintiff was treated at Dr. Ruskin's request, however, by other doctors, including Dr. Roy Brown. At no time did the Department of HEW or the Social Security Administration contact Dr. Ruskin in connection with plaintiff's disability action.

Dr. Ruskin's conclusion is that claimant has had chronic low back syndrome with severe muscle spasm and "has been totally and permanently disabled for industrial activity" since 1971. On September 30, 1977, four physical therapists independently examined plaintiff at Dr. Ruskin's request and concurred in his diagnosis. He emphasizes that his opinion is consistent with the records of the Workmen's Compensation Board that were available to the Social Security Administration at the time of the hearing.

Certain correspondence attached to Dr. Ruskin's affidavit indicates that he referred plaintiff to Dr. Roy Brown on October 12, 1977 for physical therapy. Six months later, Dr. Brown terminated the program because plaintiff had not responded to treatment.

This correspondence also reveals that plaintiff was hospitalized in February 1978 for nineteen days for exacerbation of lower back pain. Examination by Dr. Ruskin on May 18, 1978 revealed "marked low back spasm with loss of lumbar lordosis and marked limitation in range of motion, forward bending to 10 only." At the latest follow-up consultation referred to in Dr. Ruskin's affidavit, on July 18, 1979, plaintiff continued to have "severe chronic low back muscle spasm." The most recent letters from Dr. Ruskin to the Workmen's Compensation Board are requests for insurance to cover the costs of intensive hospital treatment, which Dr. Ruskin considers essential to plaintiff's recovery.

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[6] The summary, prepared by Dr. Latteri, stated: "[p]ositive findings limited to extremities. Pulses full, no edema, sensation decreased . . . in left calf . . . straight leg raising pain on left and 30 degrees on right, muscle tone decreased left calf. Impression: SP lumbar laminectomy, possible herniated disc. L-3-4, L4-5. . . . [A]ll motor and sensory deficits returned to normal. EMG findings were also normal. . . . [D]ischarged without pain . . ."

IV. [*Standards of Review*]

On review under 42 U.S.C. § 405(g), this court is not to determine *de novo* whether claimant is disabled. The Secretary's factual findings are conclusive if supported by substantial evidence, *Miles* v. HARRIS, No. 80-6186 (2d Cir. March 24, 1981); *Rivera* v. HARRIS, 623 F. 2d 212 (2d Cir. 1980), but "[w]here evidence has not been properly evaluated because of an erroneous view of the law, . . . the determination of the Secretary will not be upheld." *Marcus* v. CALIFANO, 615 F. 2d 23, 27 (2d Cir. 1979) (citing *Northcutt* v. *Califano*, 581 F. 2d 164, 67 (8th Cir. 1978)).

In assessing disability, the elements of proof on factors to be considered are (1) the objective medical facts; (2) diagnoses of medical opinions based on these facts; (3) subjective evidence of pain and disability testified to by the claimant or other; and (4) the claimant's educational background, age, and work experience. *Rivera* v. *Harris, supra*, 623 F. 2d at 216 (2d Cir. April 14, 1980) (citing, *inter alia, Gold v. Secretary of HEW, 463 F. 2d 38, 41 n. 2 (2d Cir. 1972)). Subjective evidence of disabling pain, factor number (3) above, may support a finding of disability even if it is unaccompanied by objective medical evidence.*[7] *Marcus* v. *Califano, supra; Northcutt* v. *Califano, supra; Ber* v. *Celebrezze*, 332 F. 2d 293 (2d Cir. 1964); *Stark* v. *Weinberger*, 497 F. 2d 1092 (7th Cir. 1974); *Page* v. *Celebrezze*, 311 F. 2d 757 (5th Cir. 1963). In considering subjective evidence of pain, "[t]he ALJ has discretion to evaluate the credibility of a claimant and to arrive at an independent judgment, in light of medical findings and other evidence, regarding the true extent of the pain alleged by the claimant." *Marcus* v. *Califano, supra*, 615 F. 2d at 573. To do so properly, however, the administrative law judge must first weigh "the objective medical evidence in the record, [the claimant's] demeanor, and other indicia of credibility." *Id.* Claims of disabling pain that are rejected—without consideration of their credibility—on the ground that objective, clinical findings do not establish a cause for such pain, are rejected under an erroneous legal standard, and such rejection is cause for reversal. *See id.* at 573-74.

[*Erroneous Evaluation of Pain*]

The administrative law judge's decision indicates that she placed undue weight on the lack of objective findings to support plaintiff's claims of disabling pain and in so doing contravened the rule of *Marcus* v. *Califano, supra*. In her sixth finding the administrative law judge stated that "the record medical evidence does not support the claimant's long standing allegations of pain or limitations to the extent testified to by the claimant." On the way to this finding, the ALJ remarked that "[w]hile the claimant testified the pain has been continuous[,] the medical record would not support finding the extent and severity as he testified to," and, somewhat more obliquely that "[t]he clinical and laboratory findings since the onset of the varied symptoms do not support the findings of dysfunction commensurate with the continuous symptomatology . . ." These statements strongly suggest that without considering plaintiff's credibility in respect of his claims of disabling pain, the administrative law judge rejected the claims because they were not supported by objective, clinical evidence. In light of *Marcus* v. *Califano, supra*, this was error. See *Rosario* v. *Harris*, No. 80-2016 (S. D. N. Y. April 10, 1981); *Boyle* v. *Harris*, No. 80-0836 (E. D. Pa. December 19, 1980).

Only once in her decision did the administrative law judge expressly consider plaintiff's credibility. She noted that "the record does not support, neither is full credence given to the extent and severity of the pain as he testified to." Standing alone, this statement suggests, though not as strongly as might be desired, that subjective evidence of pain was properly rejected only after it was tested against objective clinical evidence and a consideration of the claimant's credibility. This statement, however, stands in marked contrast to the administrative law judge's other statements quoted above and to her sixth finding which taken together do not entail any consideration of credibility and either expressly or impliedly relate the rejection of subjective evidence of pain to the lack of objective evidence to support it. The single reference to credibility cannot, in the context of the other statements regarding subjective evidence of pain, be considered as satisfying the teaching of *Marcus* v. *Califano* that a determination of disability may rest on credible subjective evidence of disabling pain unsupported by clinical findings or other objective evidence. The administrative law judge is directed on remand to reconsider plaintiff's testimony with respect to disabling pain in light of the rule enunciated in *Marcus* v. *Califano,* and to make detailed findings with respect to plaintiff's credibility. See *Rosario* v. HARRIS, SUPRA, slip op. at 5-6.[8]

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[7] The Secretary has promulgated a new regulation that attempts to neutralize this long-established rule of law. See 45 Fed. Reg. 55567 (to be codified as 20 C. F. R. § 404.1529). As I have recently had occasion to observe, the attempt has not been successful. *Rosario* v. *Harris*, No. 80 Civ. 2016 (S. D. N. Y. April 10, 1981).

V. [*Burdens of Proof*]

Eligibility for disability payments requires a determination by the Secretary that claimant was disabled within the meaning of the Social Security Act prior to the termination of the special earnings period. A "disability," under 42 U.S.C. § 423(d)(1)(A), is defined as the "inability to enage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Furthermore, 42 U.S.C. § 423(d)(2)(A) provides that for purposes of section 423(d)(1)(A) an individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his pervious work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. . . .

42 U.S.C. § 423(d)(5) places on claimant the burden of persuasion both as to his disability to engage in his previous work and as to his disability to engage in any other substantial gainful employment:

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

See also *Parker* v. *Harris,* 626 F. 2d 225, 231 (2d Cir. 1980); *Gold* v. *Secretary of HEW,* 463 F. 2d 38, 41 (2d Cir. 1972). The Secretary, however, bears an intermediate burden—a burden to come forward with evidence of claimant's ability to engage in other substantial grainful employment—once claimant has established a *prima facie* case of disability: Once the claimant has established a prima facie case, by showing that his impairment prevents his return to his prior employment, the burden shifts to the Secretary, who must produce evidence to show the existence of alternative substantial gainful employment which the claimant could perform, considering not only his physical capability but as well his age, his education, his experience, and his training.

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[8] Upon remand, the Secretary shall take additional evidence from Dr. Asa Ruskin, one of the plaintiff's treating physicians, with respect to plaintiff's disability.

Dr. Ruskin has submitted to this court, on plaintiff's cross-motion, an affidavit that contains evidence relevant to and probative of plaintiff's claimed impairment. The affidavit indicates a consistency in plaintiff's allegations of pain over an 8-year period beginning before the expiration of plaintiff's insured status.

While the record does not unequivocally support his claim of disability, the Ruskin affidavit shows good cause why additional evidence should be taken from Dr. Ruskin in relation to plaintiff's alleged impairment, given the substantial weight that is attached to the opinion of a treating physician. See, e.g., *Hankerson* v. *Harris,* 636 F. 2d 893, 896 (2d Cir. 1980); *Bastien* v. *Califano,* 572 F. 2d 908, 912 (2d Cir. 1978).

This evidence was not before the administrative law judge at the time of the hearing. Until June, 1980, when Congress amended § 205(g) of the Act, a court could "at any time, on good cause shown, order additional evidence to be taken before the Secretary . . ." 42 U.S.C. § 405(g). The amended statute provides that the court may order additional evidence to be taken, "but only upon a showing that there is new evidence which is material *and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding.*" 42 U.S.C. § 405(g), as amended June 9, 1980 (emphasis added). Since the statute was amended after the instant action was brought and after the return date of the motions presently before the court, cf., *Saunders* v. *Schweiker,* No. 80-163 (W. D. N. Y. February 23, 1981), it would be "manifestly unjust" to apply the amendment retroactively, since the parties have not had an opportunity to be heard regarding the absence of Dr. Ruskin's statement from the record in prior proceedings. See *Bradley v. Richmond School Board,* 416 U.S. 696, 720, (1973). Even if the new amendment did apply, good cause has been shown for the failure to incorporate Dr. Ruksin's opinion in prior proceedings. The plaintiff, a Spanish-speaking person unrepresented by counsel, might not have realized the importance attached to the treatment of treating physicians. See, e.g., *Bastien* v. *Califano, supra.* And, in any case, it was the obligation of the ALJ to insure that the record was properly developed for the benefit of the pro se plaintiff. See, e.g., *Hankerson* v. *Harris,* 636 F. 2d 893 (2d Cir. 1980). Yet, according to Dr. Ruskin's affidavit, the Secretary made no effort to contact him in connection with plaintiff's claim.

Dousewicz v. *Harris*, No. 80-6117, slip op. at 2399 (2d Cir. April 8, 1981) (quoting *Parker* v. *Harris*, *supra*, 626 F. 2d at 231). See *Hephner* v. *Mathews*, 574 F. 2d 359, 362 (6th Cir. 1978); *Bastien* v. *Califano*, 572 F. 2d 908, 9-12-13 (2d Cir. 1978); *Philips v. Department of HEW*, 453 F. Supp. 1047, 1051 (S. D. N. Y. 1978). This burden cannot be satified by the conclusory assertion that claimant is capable of doing less demanding work than that required by his previous employment: [I]t is insufficient for the Secretary to assert that [claimant] might do jobs of a light and sedentary nature . . . without providing a job description clarifying the nature of the job. . . .

Bastien v. *Califano*, *supra* at 912-13

The administrative law judge did not adduce evidence of specific jobs that claimant might be able to hold despite his inability to engage in his previous work. Nevertheless, after the administrative law judge reviewed the evidence she concluded that claimant had failed to meet his buden of proving a disability as of March 31, 1974 within the meaning of the Social Security Act and made, amoung others, the following findings:

> 7. Within the impairment[,] the claimant continued to possess on March 31, 1974 the residual capacity to engage in light and sedentary physical activity on a sustained basis.
>
> 8. The claimant in 1968 and continuing until March 1974 possessed the residual functional capacity to engage in a variety of light and sedentary work activity commensurate with his age[,] education[,] and work history.
>
> 9. The claimant's impairments did not prevent him from engaging in substantial gainful activity for any continuous period of at least 12 months which began on or before March 31, 1974.

These findings, together with the administrative law judge's ultimate determination that plaintiff was not disabled within the meaning of the Act, incorrectly imply that plaintiff established a *prima facie* case of disability, but that the Secretary produced the requisite evidence of plaintiff's ability to do other substantial gainful work. The Secretary did not, however, come forward with evidence of other work available to the plaintiff, and thus failed to meet his burden on the issue. *Cf. Dousewicz* v. *Harris*, *supra*, slip op. at 2404.

If plaintiff's evidence did not establish a *prima facie* case of disability, then there was no necessity for findings regarding plaintiff's ability to engage in light and sedentary work. If, on the other hand, plaintiff's evidence did establish a *prima facie* case, then the Secretary was obliged to produce evidence of specific jobs plaintiff could do. On remand the administrative law judge will reconsider whether claimant has established a *prima facie* case of disability. If he has, then the Secretary must come forward with evidence of specific jobs in the economy that, as of March 31, 1974, plaintiff was capable of performing and that would have provided him with substantial gainful employment.[9]

VI. [*Trial-Work Period*]

Plaintiff argues that the administrative law judge erred by considering evidence of plaintiff's attendance at an Office of Vocational Rehabilitation program in determining that plaintiff was not disabled. The record indicates that plaintiff attended the program "for about 9 months, on and off, not every week, not all the time," and did so to preserve his qualification to receive worker's compensation payments. The inclusive dates of plaintiff's attendance at the program are not specified in the record.

The statement in the administrative law judge's decision that "[b]y the claimant's own testimony he did attend [Office of Vocational Rehabilitation] training for nine months in 1974 so that he was not extensively physically or emotionally incapacitated at that time" demonstrates that she did, indeed consider plaintiff's attendance in making her disability determination. Her reference to a 9-month period in 1974, however, conflicts with plaintiff's testimony at the hearing, which suggests that at least part of plaintiff's attendance at the program was in 1973. The latter date can be reconstructed from plaintiff's testimony that a certain hospitalization in January 1974 occurred while he was attending the program. From this inconsistency in the record, I do not consider the inclusive dates of plaintiff's attendance to have been established with certainty.

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[9] I do not ignore the statement in *Parker* v. *Harris*, *supra*, slip op. at 3623, that "no useful purpose would be served here by a remand for the development of further vocational evidence." That statement, however, was at least in part the result of the Appeals Counsel's representation that it would be "inappropriate" for the administrative law judge in that case to obtain current vocational testimony on jobs appellant could have performed on the relevant date of termination of the special earnings requirement, which was June 30, 1976. A similar representation has not been made by the Appeals Council in this case. Furthermore, it may be that the administrative law judge will not require the Secretary to develop further vocational evidence if, upon reconsideration she determines that plaintiff has not established a *prima facie* case.

Under 42 U.S.C. § 422(c)(2), whether the administrative law judge properly considered evidence of plaintiff's attendance at the program depends on whether plaintiff attended and rendered services during a "period of trial work":

> (2) For purposes of section 416(i) and 423 of this title, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

42 U.S.C. § 422(c)(2). See 45 Fed. Reg. 55597 (to be codified in 20 C.F.R. § 404.1592 (1980)). See also *Sigman* v. *Califano,* 617 F. 2d 41, 43 (4th Cir. 1980); *Campbell* v. *Califano,* 483 F. Supp. 1306 (E. D. Pa. 1980); *McMillen v. Califano,* 443 F. Supp. 1362 (N. D. N.Y. 1978); *Lopez* v. *Cohen,* 295 F. Supp. 923 (S.D. Tex. 1969). The commencement, duration, and termination of the "period of trial work" are determined in accordance with section 422(c)(3) & (4).

The work performed by plaintiff in the program was performed to qualify him for worker's compensation payments, and thus was performed for "gain" within the meaning of section 422(c)(2). *Cf.* 45 Fed. Reg. 55597 (to be codified in 20 C.F.R. § 404.1592 (1980)). Nevertheless, the record does not conclusively establish the period of plaintiff's attendance at the program. Nor does the record indicate that the administrative law judge determined the "period of trial work." In the absence of these two pieces of information, it is not possible to ascertain whether or not the administrative law judge improperly considered evidence of plaintiff's attendance at the occupational rehabilitation program. On reconsideration, therefore, the Secretary is to determine the commencement and termination of the trial work period and ascertain with certainty the inclusive period of plaintiff's attendance at the program. In accordance with 42 U.S.C. § 422(c)(2), evidence of plaintiff's attendance at the program, during dates within the trial work period shall not be considered in determining whether plaintiff's disability had ceased or failed to exist in a month during that period.

VII. [*Remand*]

This discussion does require some focus upon the very difficult and demanding task which is thrust upon the administrative law judge in disability cases. It has been said that "[i]n the administrative hearing, as distinguished from the cause in this court, there are no formal adversaries," *Wray* v. *Folsom,* 166 F. Supp. 390, 395 (W. D. Ark. 1958), and the non-adversarial nature of the hearing has been cited as a basis for the obligation imposed on the administrative law judge "scrupulously and conscientiously [to] probe into, inquire of, and explore for all the relevant facts surrounding the alleged right or privilege" in cases where the claimant is unassisted by counsel. *Gold* v. *Secretary of HEW, supra,* at 43 (quoting *Henning* v. *Gardner,* 276 F. Supp. 622, 624-25 (N. D. Tex. 1967)). See *Miracle* v. *Celebrezze,* 351 F. 2d 361, 382-83 (6th Cir. 1965); *Rascoe* v. *Califano,* 483 F. Supp. 873, 877 (S. D. N. Y. 1978). See also *Dobrowolsky v. Califano,* 606 F. 2d 403, 407 (3rd Cir. 1979); *Scott* v. *Celebrezze,* 241 F. Supp. 733, 736 n. 21 (S.D.N.Y. 1965).

In this "non-adversarial" setting, however, reviewing courts have imposed adversarial burdens upon the parties, such as the evidentiary burdens here discussed. In the many cases like this one where neither the claimant nor the Secretary is represented by counsel, the adminisrative law judge has the duty "to protect the rights of both the claimant and the Secretary." J. Smith, *Social Security Appeals in Disability Cases,* 28 Ad. L. Rev. 13, 14 (1976). Thus at the very time she is "scrupulously" inquiring into the facts surrounding claimant's claim, and prior to rendering a final disability determination which will require her to weigh the evidence and make findings of fact, she must also see to it that the Secretary meets his burden of coming forward with adequate evidence. It is no wonder that from this confusion of roles error results.

The protean nature of the ALJ's role is illustrated by the path the instant case may take on remand. If plaintiff establishes a *prima facie* case of disability—a determination to be made by the administrative law judge in her judicial capacity—it thereupon will become the administrative law judge's duty, in seeing to it that the Secretary's evidentiary burdens are met, to adduce evidence of specific work in the economy that, given his limitations, plaintiff could have performed in the relevant period. Such evidence is normally presented through the testimony of a vocational expert, who will be called and questioned by the administrative law judge in discharge of her duty to protect the rights of the Secretary. Where, as here, the claimant was not represented by counsel, the administrative law judge must also protect the rights of the plaintiff by carefully probing for weaknesses in the vocational expert's testimony, as applied to the claimant's situation. The inadequacy of this procedure, as measured by its likelihood to yield an accurate evaluation of a claimant's abilities in light of available work, has been elsewhere noted, *Dobrowolsky* v. Califano, supra, at 408 &n. 14 (citing and quoting *J. Mashaw, et al., Social Security Hearings and Appeals 77-78,* 86 (1978)).

Thus roles that in courts are kept distinct—those of advocates for either side, and that of judge—in disability administrative hearings become fused and are collectively performed by the administrative law judge, who routinely serves as advocate for both sides and as judge. This requirement that the administrative law judge remain impartial while performing advocacy functions in essentially non-adversarial proceedings creats a tension between the intended and actual natures of the disability hearing which leads to error with alarming frequency. The incident of error in disability hearings suggests that the present regime simply is not working. The time has come to reexamine the procedures to be followed in such hearings.

This case is placed on the suspense docket of this court pending further proceedings of the Secretary.

So ordered.

Chairman PICKLE. I thank both of you, gentlemen, and your statements are very helpful to us.

Both of you have rather lengthy statements with exhibits and supplements attached. So the committee will ask the staff to go into those in more detail, and as a result they may have individual questions to ask you, which we will not be able to cover this morning in the interest of time. I want you to know, though, that we are mindful of your entire testimony, and we will be following it closely.

I have two or three questions that I want to ask of a general nature. First, from you, Judge Bono.

The administration has proposed that they hire some 140 new administrative law judges this coming year. They have also recommended that there be an increase in the productivity of ALJ's to 45 per month.

First, would it be possible for them to hire 140 administrative law judges; can they achieve that goal?

Judge BONO. As we are informed, the recent hiring of approximately 42 administrative law judges from the Office of Personnel Management Register was very successful. We had indications from the Office of Personnel Management that there are many qualified individuals on their registers seeking jobs. It is not, as it has been in the past, a problem as far as presently is concerned.

There are some questions which don't seem to be readily answered at this point as to the total 140 which are mentioned, but it looks favorable at this time from the standpoint of supply of qualified individuals on the register.

Chairman PICKLE. Your answer is that they will be able to hire without creating any difficulties the 140 administrative law judges that they are interested in?

Judge BONO. I would believe, if the present indications are to be relied on, this could be accomplished.

Chairman PICKLE. Now, will they be able to increase their productivity to the 45 cases per month?

Judge Bono. That is an excellent question, Mr. Chairman, and it is one which the administrative law judges in the Office of Hearings and Appeals have had to wrestle with for many, many years as you are aware.

There was a time when 20 decisions per month per judge was considered a goal, and considered a great accomplishment. The administrative law judges in the Office of Hearings and Appeals have even surprised themselves with what they have been able to do over the years.

I was an advocate at one time that 26 decisions per month was almost an impossibility for most judges to be able to hear that many cases, and decide them on their own, and to write them on their own.

The fact of the matter is that national averages are somewhat meaningless to a promise by an individual administrative law judge as to whether he can give 45 decisions a month. I think that is the trap we fall into. In our discussions with the Associate Commissioner, Mr. Hays, about the possibility of being able to accomplish this national average, there were many reservations on the part of the officers of the association with respect to being able to give such a commitment.

No. 1, the Association of Administrative Law Judges cannot readily make such a prediction. Forty-five decisions a month requires a national average of that much per each judge. It does not take into consideration travel considerations, vacation time, staff shortages.

We have reports that some judges are issuing 100 decisions a month, therefore, they would bring up another judge who was not issuing 45. But the point is, when you talk about 45 decisions per month as a management initiative, it suddenly begins to be not a goal, it becomes a quota, and everything is geared toward that.

This is why my answer is long to your question, and I apologize for that, but I wish I could give you a very short answer of yes or no.

Chairman Pickle. I don't suppose any of us can know exactly whether this is the right approach. But our problem, as we see it, is that you have a backlog that is growing from 125,000 up to 200,000 within the next 2 or 3 years. With that kind of a backlog, and it possibly increasing, we know that a certain number of cases must be turned out, or some other procedure has got to be adopted.

You take the position that it would be a mistake to appoint anyone other than through the APA procedures. You very strongly said, we ought not to do it, and we ought to keep within the administrative law judge structure. I think your people would remove you from office if you took a position to the contrary. I accept that.

At the same time, and I am not trying to examine your loyalty to your group whether it is the right one or not, but how do we handle these cases? I don't want to get into quotas, but if we aren't able to do what we are saying, then what is your alternative. Do you have an alternative?

Judge Bono. First of all, let me say that I know that the presently reported average nationally of the judges is 32.5, and what you are talking about here is 45 per judge. I would like to be optimistic and say, yes, that can be achieved. I think the Associate Commissioner has been optimistic and said that can be achieved.

The only point I would like to make is, no alternatives are needed other than the APA process. Within the APA process, there are alternatives to solve this continuing problem, so that 5 years down the road we don't ask for 100 decisions from each judge.

It was part of my point that the effectiveness of the appeals process must be elevated, and that could be helped by something which we mention in the paper, power of remand. We have no such effective power. This would ultimately reduce this backlog if we had a power of remand with order.

As far as alternatives to the system of hiring non-APA qualified individuals to hear the cases, I don't believe that is a viable alternative.

Chairman PICKLE. I am not going to dwell on this point. I am saying that we have a very practical problem of numbers, and a lot of it may be brought on by the accelerated review pushed upon the State agencies because the increase in workload may be 30 to 50 percent.

You have a huge backlog, and either we pick up productivity, or we are going to go some other route, or a combination of routes, because we have no alternative. I don't know for sure what is the right course of action.

Judge BONO. Mr. Chairman, may I reply to that.

I don't want to lead this subcommittee to believe that the judges in the field are not willing to work harder and harder. They have given ultimate history that they have given more when we did not expect that they could give much more.

We will attempt to continue on and help to achieve a goal, so to speak, of 45 decisions per month, but it is very important that this subcommittee realize that when you speak of increasing production, with increased staff and increased equipment, that increased staff and increased equipment must be real, it cannot be promised, and then never occur, and then expect the judges to do 45 cases per month.

Chairman PICKLE. I am not going to argue with you about that.

Judge BONO. I don't mean to argue.

Chairman PICKLE. We have got to get productivity, or else we are going to be swallowed up, and we can't let that happen.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Thank you both for your testimony.

In addition to making sure that there are administrative law judges to do the job, what other steps are there which could be taken by the Congress to assist you in meeting this problem, or is your problem primarily with the executive branch?

Judge BROWN. Are you addressing that question to Judge Bono, or to myself?

Mr. GRADISON. Either one.

Judge BROWN. I would say that more consideration could well be given to providing more regulatory guidance, as I have indicated in my statement, for the benefit of the State agencies.

I believe that over the last 2 years in particular, judges pretty uniformly have observed that we are seeing many cases, as I put it, that we shouldn't see at the hearing level, and this explains why you have a situation where there has been somewhat of a drop in disability applications initially, and yet the workload at the hearing level has gone up. I think a closer look would have some rich benefits, if you look at how the State agencies decide the cases.

As far as the Congress is concerned, I don't need to tell you what your job is, but I think your oversight responsibility is applicable here. I think this explains another concern that social security has lightly observed, and that is the so-called problem with the reversal rate. I think that there is eloquent testimony confirming the point that I made.

Mr. GRADISON. I see this from my own point of view, two ways. First, as the cases that come through my office. I find it astonishing, in the 7 years I have been here, the frequency with which reversals did take place. This suggests to me that there are a lot of cases that are not properly being taken care of in the first place.

As one member, I would look forward to a day when practically nobody came to us because they felt they got a fair shake the first time, and they had not heard from their neighbors yet that if you went through this appeals procedure, you might come out better.

Judge BROWN. If I could respond to that, Congressman.

You are never going to have a perfect system in which there will never be any so-called reversals at our level because there is always the opportunity for additional evidence.

The State agency decision could be as right as rain, so to speak, yet we have different evidence. By definition we have different evidence as soon as that claimant walks into the hearing room, and we get to observe him and question him expertly as we are trained to do.

So I think you will always have to remember that there is going to be some difference because of differences in records, and the fact that people's disabilities are not static. They get better and they get worse, and new information can cast an entirely different picture.

So I think that that is something that is not always well understood when we start comparing decisional rates, so-called reversal rates. But I think that more can be done to make sure that the cases that come to the hearing level are what I call truly controversial cases.

Mr. GRADISON. Recognizing that we want justice done, and people to benefit, can pinpoint any steps that we might take in terms of eligibility that would give more certainty to this process, or are we really driven by the desire to aid the disabled, and the vagueness of what that means, to live with the present statutory standard?

Judge BROWN. My initial response to your question is that I think that the statute as it is presently written, and was last modified in 1967-68, is a pretty good definition. But I certainly would have to admit that Congress could refine the definition if it were of a mind to do so.

For example, there are certain specific items in the statute, that is, defining medically determinable impairment, defining the issue of availability of jobs when there are vocational considerations. This was a problem that Congress had to address in the 1967 amendments.

I don't have any specific suggestions as to how the language could be changed. There could be room, though, for refinement.

Mr. **Gradison**. Thank you.

I don't want to belabor this, but I just want to say to the chairman that I would think that these witnesses would be in a particularly good position, as a group, to advise us from time to time.

You see these people coming and going, and you are trying to apply the standards set by protocol and the interpretations by the courts. Believe me, I am not raising this to try to get a quick fix that makes it possible to make decisions by formula, but since we don't exercise, perhaps, as continuing oversight as some of us would perhaps like to in this area.

Since you are living with it all the time, I just would like to say for this member, if in the normal workings of your national organization, you come up with suggestions that relate to the statutory definition, don't be shy about passing them on to us. They would certainly be welcomed, and carefully considered.

Chairman **Pickle**. Of course, they would be welcomed, and I hope you would send us your suggestions about the definition.

Let me pursue that a little bit more. I don't want to take the other gentlemen's time, and I see that Mr. Seiberling has come in.

I want to ask you, Judge Brown, or either one of you, approximately 80 percent of the cases are denied at the State agency level. The administrative law judges, though, will reverse approximately 60 percent of those on appeal. That is a great disparity. Eighty percent are denied, and of those that are appealed, you reverse 60 percent of them.

The average citizen looks at that figure and he says, "There is something wrong. All you have to do is appeal, and you get it reversed." That is what they are doing, and I don't think anybody would deny that. It just seems to me that on the face of it, there is a figure that is subject to closer examination, and can we do anything about it.

My question to you is: The State agencies make the determinations, and they follow their books, the POMS, and other guidelines; you come along and look at those same cases through different regulations, different guidelines, and evidently come to different conclusions. The fact of the matter is, you are both reading from different books, and different rules, different regulations. How can you get together along the lines, as Mr. Gradison said, somehow or another to establish a better definition, or a better getting together?

But you are not getting together, and that is one big reason for these huge number of cases being appealed, plus the fact that there is an attitude that if you appeal, you are going to get it reversed, so just stay with it. The attorneys will say, "Stay with it," and the persons will pursue it on to the last.

Judge **Brown**. I agree wholeheartedly with your observation. What I have tried to suggest on behalf of the judges is that more attention ought to be paid to incorporating instructions and criteria into regulations.

I don't discount for one moment congressional involvement, as I indicated to Mr. Gradison's question. I do think that the preferred area would be to promulgate regulations which the Secretary can do under the statute.

I think, also, there should be discussions in the Social Security Administration itself between judges and those who govern the disability program in headqarters in Baltimore to try to work out specifically where these areas of specific difference are.

I think with a give and take type of discussion like that, we can make a lot of progress. I think the judges are perfectly willing to cooperate, more than willing to cooperate with that.

Finally, in the analysis, I think you have to take into account that part of that 60 percent is not attributable to the difference in standards. Part of that is attributable to what I just mentioned a few moments ago about the fact of a difference in records that you are never going to get away from because the States may do the job correctly, and the decision may not be subject to question, but we get different information, and a different conclusion is going to develop.

Chairman **Pickle**. I think it would be well to have discussions and review of some of these areas where you could have agreement. But we look at it at this point, at least I do as the chairman of this subcommittee, we have had the chance to review and discuss this for years, and this great disparity still exists, and this committee is thinking seriously of setting the standard ourselves for you to follow if you don't get together on it.

Judge **Brown**. All right.

Chairman **Pickle**. Because we can't allow these eternal delays.

I have further questions, but I am not going to pursue them at this point because we have got several witness, and we have spent 1 hour on this one panel.

I am going to recognize Mr. Shannon.

Mr. **Shannon**. Thank you, Mr. Chairman.

If either one of the witnesses would answer this question.

Under the present system it is impossible for the staff attorneys to become administrative law judges. From the perspective of productivity and efficiency of the system, and from the perspective of moral, do you think this is something that we should address?

Judge **Bono**. I would answer that, Mr. Shannon, by saying that it is something seriously needs to be addressed. There is a morale factor here as far as the staff attorneys office is concerned. I believe the vice president of the Staff Attorneys Association has filed a paper with this committee in that respect.

It is a great concern because the staff attorneys, as I understand it, have a level of qualification problem in their present grade of 12. They have taken the position, as I understand, which will be further elaborated on shortly that they need to get out of this quandary.

As we all know, it was originally conceived as a 2-year program. It is not fair to the staff attorneys program as it is now constituted.

Mr. **Shannon**. Do you think that the system would work more efficiently if we could have staff attorneys become administrative law judges?

Judge **Bono**. I think the staff attorneys should be given a way of getting to that position. There are divergent opinions on the qualifying experience they should have. As their jobs are presently constituted, and by reason of the numbers, they are being relegated to decision writers, although their position descriptions are far beyond that.

Mr. SHANNON. It is possible for a para-legal or for an analyst to become an administrative law judge directly, but not possible for a staff attorney.

Judge BONO. They have to be an attorney. They can go that road, as I understand it, by the analyst process which qualifies as a 14, I believe, but they must be admitted to the bar in order to become qualified.

Mr. SHANNON. You do have an anomalous situation where it is technically possible for a para-legal to become an administrative law judge, but not for a staff attorney to become an administrative law judge.

Judge BONO. If I can answer that specifically, Mr. Shannon. Because it is a dead-end job at grade 12, and in order to qualify for an administrative law judge position you must be at a grade 14 level, preferably for at least 2 years, that is the hurdle that is there. It is the barrier that is there.

Mr. SHANNON. There was a period, I think, a few years ago when staff attorney involved in the SSI cases and the black lung cases were able to become administrative law judges.

Judge BONO. If I could modestly correct you, sir.

Mr. SHANNON. Go ahead.

Judge BONO. What you are making reference to are the temporary Hearing Examiners that were hired because of the SSI workload that developed in 1974 because of the title 16 to the Social Security Act. That was a very difficult time both with those temporary hearing officers, and the temporary hearing officers for black lung.

I know this committee knows well the history of the problems that deal with hiring of temporary hearing officers, and this explains our position on that particular point. There was just a bad problem there which we hope not to be repeated.

Mr. JACOBS. They were all grandfathered in, were they not?

Judge BONO. Yes, subsequently, but it took the action of this committee when other areas were not willing to take the bull by the horns, so to speak.

Mr. SHANNON. Thank you very much.

Chairman PICKLE. Mr. Heftel.

Mr. HEFTEL. Thank you very much, Mr. Chairman.

I think I Just want to echo what has already been pointed out, namely, that the system cannot function either efficiently or effectively if you are running 60-percent reversals. There is something wrong, and it probably would behoove the committee to look at the need for standards coming from the legislative process, rather than from an adjudicative process.

At the present time, your criteria are established by precedent, prior cases, and it appears that at the State level some kind of judgment and standards are being used, which are less subjective, and which try to resist, if you will, the subjective evidence that would normally be the reason for reversal.

I am wondering if the reversals are really just a process of becoming more subjective than was the original staff. Is it just a subjective consideration which is resulting in the high reversal rate?

Judge **Brown**. Mr. Heftel, I would like to answer the question in this way. I believe subjective considerations play a very limited part in the explanation of the 60-percent reversal rate at the hearing level. Just to give you my own personal example, in my decisionmaking, I find that the number of cases that I allow is based on logic, and the fact that a person meets the listings, that is, meets the presumptive criteria for disability, and I think there is very little in those decisions that is subjective. I think it is the fact that not always is full inquiry taking place before we get the cases, and not always all the evidence is in, so to speak.

While I recognize that to some extent the subjective factors play a part, I believe the more prominent explanation has to do with the nature of the inquiry with respect to medical development, as well as questioning the claimant at hearing fact to face.

Mr. **Heftel**. For instance, normally, you would not be using educational background, you would not be using work history, and you probably would be looking at the individual to try to determine if there is an incapacitating disability, and not going behind that to determine whether in view of a person's age education, and so on, the person will have a difficult time obtaining certain types of funds.

Is that going too far into a subjective analysis of the case? Should we be establishing a much more rigid standard that tries to overcome this reversal rate, but which also looks at the financial capacity of the system because a bankrupt system is not going to help anyone?

Judge **Brown**. I would say that your question suggests one of the proposals which has been made about using the listings, the medical criteria only, as the test for disability. I think that that approach has got some significant limitations, particularly when one takes into account the experience of judicial review.

I think the natural response that we would be subjected to as administrative law judges would be increasing criteria from the district courts as to ascertaining whether or not the medical test for disability was satisfied. I think that while that is obviously within the province of Congress to make the change, I think that you should be aware that there may be some significant practical limitations to that approach.

I do feel, second, that education is not necessarily a subjective element. I guess what the thrust of your question is whether or not there is a subjective interpretation of the impact of education on the issue of whether or not a person is disabled. I think that the 1979 amendments to the disability regulations went a long way in that regard to provide definitions with respect to what the significance of age and education, and work experience mean as far as social security disability is concerned.

I think that from what I can tell, probably all of the levels of adjudication follow what those regulations have to say about age, education, and work experience. I think the problem lies more with respect to the issue of difference in standards on the area of how you determine the significance of the limitations that there are from the medical impairments.

I think that is where the different standards issue really revolves.

Mr. **Heftel**. I think, though, so long as you have a 60-percent reversal ratio, we are dealing with inadequate controls or standards, and we are failing to impose the same standards at each level. I don't think that you could have reasonable men and women making judgments on the same rigid standards coming up with 60 percent reversal rates. There has got to be something inherently wrong with the way we are allowing two different groups to use standards in evaluating disability.

Judge **Brown**. I think there is agreement with that statement.

Chairman **Pickle**. You have different standards on the administrative aspects, and you have different standards on the medical aspects, so it is compounded when you serve both.

Do you have any questions, Mr. Rousselot?

Mr. **Rousselot**. This is a very complete statement.

Chairman **Pickle**. Let me ask you before you leave, and give me a yes or no answer, and you can give me a legal analysis later.

A lot of people have alleged that claimants are withholding medical evidence at the State level because they feel they will get a better deal when they appear before the administrative law judges. Do you think that is true?

Judge **Bono**. As far as my own personal observation, I have seen no evidence of that of any significance, and I have not had it brought to my attention as vice president of the association.

Judge **Brown**. My quick answer is no, but if you want me to elaborate on that with the satff, if they would like to inquire of me, I will be glad to respond in detail.

Chairman **Pickle**. The State disability examiners are going to testify later, and they are going to have statements, perhaps opposite to what you say, and your answer could be made in response to those statements.

Judge **Brown**. We have no information to that effect.

Chairman **Pickle**. You are both satisfied with what the attorneys receive at this time; should we stay with that?

We have another serious problem that has been thrown upon us by "equal access to justice" legislation; is the 25 percent allowed under existing law working out satisfactorily?

Judge **Brown**. I think it is adequate in 99 percent of the cases as far as the attorneys are concerned.

Judge **Bono**. I would agree with that.

Chairman **Pickle**. I have several questions, and I am sorry that I cannot ask them now, but I must move on. We thank you gentlemen, very much.

[The following was subsequently received:]

SUPPLEMENTAL STATEMENT OF ASSOCIATION OF ALJ'S

This paper is intended to expand upon the statements made on October 28, 1981, by Association Vice President ALJ Charles N. Bono, and Director ALJ Ainsworth J. Brown.

These most interesting and effective presentations expressed a number of positions taken by the ALJ Association. However, the exigencies of time naturally limited their statements to those areas the Association felt it had to address at that particular point in time. The following material is intended to supplement those statements as well as to reflect the Association's continuing initiative towards improving our system of justice by the presentation of a series of position papers addressing current problems as well as future problems as they arise.

The Association is painfully aware of the exploding caseload at OHA and has explained its genesis in the statement presented by Judge Bono. Whatever its genesis, however, it must be "handled" and the Association, while reserving its right to point out other level actions exacerbating the flood of cases at OHA, does assert on behalf of its membership its confidence that ALJs can and will meet their responsibilities as they always have in the past (assuming the providing of increased support personnel and resources, innovative case processing techniques, and updated equipment), and, further, declares that it expressly undertakes its appropriate share of responsibility for identifying and positing solutions to the overall continuing problem of disability adjudication at all levels.

In that connection much has recently been made of an excessive ALJ allowance rate. We would, at this time, point out that of the total allowances made by SSA in FY-79, (510,460) ALJs allowed 16.7% of that total. At the same time, initial allowances were 73.5% and recon allowances were 9.3%. In FY-80, of the total allowances (497,135), ALJs allowed 20.6% of the total. For this period, initial allowances were 69.5% and recon allowances were 9.4%. It is a matter of simple arithmetic to note that the 3.9% increase in ALJ allowances matches up almost identically with the initial allowance decrease of 4% for the periods described. Therefore, the issue of ALJ allowances during this period seems actually to be a non-issue. The amount of ALJ allowances for

FY-79 and FY-[illegible]0, when viewed against the total allowances made at lower levels, seems quite consonant with anticipated allowances as such cases proceed to hearing and decision with all the attendant factors of increasing age, worsening physical and emotional conditions, developing of new evidence, and the impact and ramifications of face to face de novo, due process procedures. We, therefore, respectfully suggest that undue emphasis has been placed on the ALJ allowance rate with an invalid inference being drawn as to the existence of a problem which is probably little more than a "de minimis" situation.

We feel, therefore, that emphasis would be more profitably placed on those areas which seem to cry out for careful exploration. Despite our aforementioned feeling that too much has been made of the so-called "ALJ Reversal Rate Problem", as lawyers and judges we also feel that our ability to reduce the allegations of excess made against us to relatively insignificant proportions does not mean that there might not be some profit in searching for answers by reviewing just what the whole ALJ "reversal" picture entails.

To that end, we posit the following questions:

1. Can we determine what factors result in ALJ reversal of lower determinations?
2. Are ~~Is~~ there a significant number ~~amount~~ of ALJ decisions which are the result of different standards of adjudication, apart from the expected variances occasioned by face to face contact~~s~~ in the hearing context?
3. Where, if at all, are the significant variations between State Agencies and ALJs?
4. Are these variations amenable to in-house procedures which will occasion more consistency and, at the same time, be commensurate with due process?

In order to better understand why a reversal takes place, one must first understand that there are no simple answers. However, a complicated answer does exist and we herewith present same.

Reversals, in our present non-adversary de novo hearing process, are a complex of (1) the inherently amorphous nature of the abstract capacity for gainful activity when applied to claimants with some quantum of residual work capacity; (2) the borderline situation in most of the cases which fall outside "per se" rules; (3) the necessity of and difficulty in assessing psychological overlay in borderline cases; (4) the conclusory opinions and paucity of objective findings by independent, one-time examiners, vis a vis the recital of objective findings by long-term treating physicians, in medical reports which necessarily form a great part of the evidence before ALJs and make their judgement as to claimant's credibility all the more vital; (5) the face-to-face contact and burden of proof considerations which first come into play with telling effect at the de novo ALJ hearing; (6) the presence of claimant's attorney in non-adversary proceedings, who, in a borderline case, can always make a plausible argument, and by his mere presence connotes the probability of appeal; (7) the inherent statutory responsibility of the ALJ to exert his independence of judgement and long-recognized responsibility to aid unrepresented claimants, which quite correctly results in significant numbers of allowances; and (8) most strikingly, the recently adopted regulatory medical-vocational guidelines (2/26/79) which have not only occasioned great confusion and differing interpretations at the higher court levels, but have also created a definition of total disability, which, for the first time, and, in our opinion, in contravention of the statutory scheme, "directs" ALJs to find disability where certain categories of claimants are concerned even if these claimants retain the residual functional capacity to perform medium, light and/or sedentary work.

Along the lines that Judge Brown suggested in his statement, the Association of ALJs feels, that, of these areas of explanation and potential for variance, only two are susceptible to in-house change of procedure which would promote due process uniformity between the lower levels and the de novo trier of the facts and law. Those items are numbers (6) and (8).

The material covered by numbers (6) and (8) have, with the expected increasing expertise of the disability bar, resulted in greater difficulty for the ALJ since he cannot assume even the appearance of an adversary posture and still carry out his statutory responsibility, and very often is constrained to come to conclusions which may be at odds with his independent judgement and understanding of the law. Associate Commissioner Hays has, with Association encouragement, begun to set in motion efforts to establish experimental adversary procedures which we feel will result in more effective presentation of the Government's case in a non-go-for-the-jugular, in-house, adversary proceeding in keeping with Congressional intent that claimants should not have an unreasonable burden imposed upon them when presenting their side of their cases. We think that these experiments will prove successful, since they enjoy broad-based support among ALJs, and, not surprisingly, considerable support among the members of the Bar.

Certain advocacy techniques have evolved, which when used by experienced lawyers tend to put the Government at a disadvantage. These techniques, combining the factors described in numbers (6) and (8), tend to consist of the submission of heavily-weighted favorable documentary evidence, vigorous cross-examination of expert witnesses, and judicious and discreet use of the medical-vocational guidelines or "grids". This "strong" and proper representation by well-armed advocates devolving into the ALJ's increasing workload, in our opinion, now mandates a kind of government representation which was heretofore not required. Effective government representation will certainly counter this "loading" factor inherent in the first two advocacy techniques heretofore described, but the last technique cannot be overcome without a policy change by SSA.

Before undertaking a discussion of what policy change the Association recommends, the reader must understand how the new regulations and medical-vocational guidelines, in their present form, promote agency disharmony and work against the Administration as well as contravening the statutory definition of disability.

Under the aforementioned Regs, "sequential evaluation" was established which was intended to more definitively deal with the burden of proof in disability cases. The most significant part of the sequential evaluation provides that a finding of a "severe" impairment must be made in order for claimant to be able to carry his initial burden of making a prima facie showing of disability which will then require the Secretary to go forward with the evidence to show what jobs the claimant can perform within the national economy, consistent with the statutory definition of disability.

> "Section 223(d)(1) The term "disability" means -
> (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; r (2)
> For purposes of paragraph (1)(A) -
> (A) an individual (except a widow, surviving divorced wife, or widower) for purposes of section 202(e) or (f) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country."

A finding of "severe" plugs the following claimant profiles into a finding of disability despite the simultaneous finding that the claimant has the residual functional capacity to perform medium, light, or sedentary work in the following instances:

Table 3, 203.01, 02, 10. Table 2, 202.01, 02, 04, 06, 09, Table 1,
201.01, 02, 04, 06, 09, 10, 12 14, 17.

As one can see, these categories represent a significant number of cases. The State Agency disability examiners, when evaluating these types of cases, must use the sequence, and when the accordingly (as they must), ascertain that the plugging in of one of the above vocational profiles will result in a finding of disability, they tend, in a rather pronounced fashion, to stop the sequence at "not severe", thus avoiding resort to the"grids" and enabling them to come to a finding of non-disability. When the ALJ uses the same evaluation and also takes into consideration the statutory definition and well-established burden of proof precedents, he/she will come to a finding of a "severe" impairment and, thus, be required to reach a "directed" finding of disability. Thus, it is clear that the most substantial variance between lower level adjudicators and ALJs, which inevitably must result in "reversal" by ALJs, occurs on this point. While there are substantial problems with both the present sequence and the "grid", we do not, at this time, recommend a discarding of these regulations. We do, however, recommend that the Secretary make a policy change which would not only significantly reduce the variance between the State Agency and ALJs but would also reduce any "noted" increasing reversal rate at the ALJ level. From the very beginning, it has been recognized that a finding of non-disability in the grid may be rebutted by the claimant. In other words, a directed finding of non-disability cannot be a "conclusive" presumption but only a "rebuttable" presumption. One might assume that equitable principles would require that a directed finding of disability would also be a presumption capable of being rebutted by credible medical and vocational evidence to the contrary. In practice, however, this has not been SSA's policy. Therefore, the State Agencies, in their attempt to fulfill their primary mission of safeguarding the fisc have, perhaps understandably, resorted to the expediency of a "non-severe" finding in a case that would otherwise have to be allowed. They have then "kicked the case upstairs" to the ALJs who must "reverse" and "pay the case". This, of course, is the quintessence of "institutional sand-bagging".

We feel that the Secretary should issue a policy ruling, expressly stating that all "directed" findings of disability or non-disability are simply rebuttable presumptions, which can be overcome by credible medical and vocational evidence to the contrary. Such a ruling would permit the State Agencies to conclude that a "severe" impairment can obtain without the fear that such a finding would automatically require "paying the case" even though the disability examiner feels that payment is not warranted. This same application of the presumptive approach used by the ALJ who must find "severe" impairments in most of these cases, would result in a significant number of denials which are now "reversals", in effect, by administrative fiat. Such a policy ruling would not only promote the kind of uniformity which is currently being sought, but also permit a return to well-established previous practice allowing all levels of adjudication to deny benefits to claimants on a more realistic basis, that is, no case should be allowed where, regardless of age, previous work experience or lack of it, claimants retain the residual functional capacity to engage in substantial gainful activity.

In summary, the Association position with respect to the question of lack of uniformity of procedure at the State Agency and ALJ levels, and its corrolary, allegedly excessive reversal rate, superimposed upon the mosaic of an ever-increasing caseload, is that the question can be substantially answered by a two-pronged approach. This approach consists of (1) allowing the Government to present its case more effectively through the use of in-house adversary proceedings, thus disposing of its cases in greater numbers with better records and (2) a policy ruling as to the designation of "rebuttable presumptions", which will permit more consistent application of the medical-vocational regulations at all levels, and have the effect of reducing that part of ALJ "reversals" which have been foisted upon us by artificial administrative fiat as described heretofore. The result will be an increase in dispositions, a decrease in the current reversal rate and, therefore, an obviating of any necessity for any extraordinary addition of large numbers of new Administrative Law Judges.

Respectfully submitted,

JUDGE PAUL ROSENTHAL
President, Association of ALJs in HHS

With Contribution By
JUDGE BARRY M. WESKER
Director, Region IX
Chairman, Position Paper Committee

Dated: November 25, 1981

Chairman PICKLE. I would ask Congressman Seiberling if he would like to present his testimony. You can talk to us from your vantage point to the right of the Chair, or you may go to the table.

Mr. SEIBERLING. If the acoustics permit, I will just stay in this seat, and proceed.

Chairman PICKLE. The Chair recognizes the gentleman from Ohio.

STATEMENT OF HON. JOHN F. SEIBERLING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. SEIBERLING. Thank you, Mr. Chairman.

I have a prepared statement, which the staff is passing out. I will not try to read it. I would simply ask unanimous consent that it be included in the record, and I would like permission to summarize the principal points, Mr. Chairman.

Chairman PICKLE. Without objection, so ordered.

Mr. SEIBERLING. Mr. Chairman, and members of the subcommittee. I do appreciate the opportunity to appear before you. As you know, I appeared in 1975, testifying in support of legislation to add more administrative law judges to the Office of Hearings and Appeals in order to reduce at that time the tremendous backlog. At that time there were 111,000 requests for hearings pending, and the medium processing time was 224 days.

In July of 1977, I again testified before you, and at that time there were 85,235 requests pending, and the average processing time nationally was 211 days.

Subsequent to that, a report was sent to Congress last year recommending that hearing time be limited to 160 days, and the appeals process to 120 days. As you know, the most recently available statistics indicate there are 128,000 cases pending for hearing, and the average processing time is 168 days.

What it adds up to, Mr. Chairman, is that the self-imposed time limit that was imposed under pressure by this subcommittee is simply not being met. In my district, the processing time is way over the national average. Some of my constituents must wait almost a year from the date of filing for a hearing before they can be heard. As you know, the predictions are that the situation will worsen.

To address this problem, I introduced the Social Security Rights Act, H.R. 4775, which would establish mandatory time limits for the processing of social security claims. The initial and reconsideration decisions would have to be made within 90 days, and the hearings and appeals process would be limited to 120 days. I would propose that decisions in any hearings and appeals procedure occasioned by a cessation order be made within 60 days.

An important feature of this bill is that it would also provide emergency benefits to claimants who did not receive decisions on their claims within the time required. The benefits would be based on the recipients' earnings records, and would not subject to the overpayment provisions of the Social Security Act if the claim were ultimately denied after the appeal was completed.

This, undoubtedly, will add to the cost of the system, but it does give the administration the option of reducing these costs by adequately staffing the appeal system with the administrative law judges and supporting staff.

Mr. Chairman, and my colleagues, it is simply time, if there is going to be loss, that the system pay for improvement, rather than the unfortunate individuals whose rights are impaired by these delays, and who in many cases simply cannot do without their benefits.

I would just like to give you a specific example of why it is not being adequately staffed. Three administrative law judges were recently added to the Cleveland office, where my constituents' claims are handled, but because of budget constraints imposed under the current economic program, no funds were provided for support staff for the new administrative law judges.

I cannot emphasize more what the preceding witnesses said, and what the vice president of the Administrative Law Judges Association is absolutely right. It doesn't do much good to add new judges, unless you are going to give them supporting staff. I just hope that the administration faces up to that.

As you know, Mr. Chairman, and my colleagues, time when it is applied to other benefit programs, such as food stamps, and aid to parents with dependent children, the eligibility is based on needs, not as in the case of social security claims on prior contributions. It does seem to me that it is time to extend the same rights to individuals who paid to the social security trust fund through the payroll tax.

I will bow to the expertise of this committee. I think some of the remarks that were made here today by the members are right on target. I read through the prepared statements of your other witnesses, and it seems to me that some very, very good points are made, but none of them have focused on what I think is the greatest injustice that the cost of the delay is borne by the people whose rights are being impaired to the extent that their rights are ultimately upheld, but only after a long delay.

Chairman PICKLE. Mr. Seiberling, I appreciate your testimony. I appreciate your interest in the social security field in general because you have appeared before us on other occasions and have given excellent testimony.

The Chair is going to submit this measure which you have introduced to the Social Security Administration, and to the Office of Hearings and Appeals, and to other agencies, because I want to get their reaction.

My question to you would be, are we encountering a due process difficulty here under the measure you propose?

Mr. SEIBERLING. I don't think so because the only due process problem is if an individual is denied. This, it seems to me, is a reasonable compromise. It allows for some delay, but it says that if the delay goes beyond the reasonable time, then he is going to be made whole until the decision is finally forthcoming.

It seems to me that that is not a due process problem. The due process problem exists at present when people are delayed beyond what I think is a reasonable time period.

Chairman PICKLE. If the decision were not reached within the 120 days, a partial benefit should be given to the claimant, and it would not be the subject of recoupment even if he were denied later.

Mr. SEIBERLING. In the majority of cases, there is going to be no problem because the experience has been, as it was brought out today, that in most cases the decisions are being reversed. Therefore, we are dealing with a minority of the claimants who would get, during the period after 120 days until the decision was made, their claims satisfied. The remedy is to provide adequate staff so that those claims are not delayed beyond 120 days.

Chairman PICKLE. The Chair is going to depart from the normal procedure, and question Judge Brown and Judge Bono from the audience.

Do you think it would be acceptable to establish a limit of 120 days to adjudicate the case?

Judge BROWN. Under the present circumstances, and the given number of cases, whatever that percentage may be, there is going to be considerable difficulty in attaining that limit.

I think we all recognize that there is a problem, the resources that are going to be devoted to achieving this goal. I think we would all like to get there, but the question is how much money are you willing to devote to get to that point.

Chairman **PICKLE**. My question to you would be, would you favor a limitation of 120 days?

Judge **BROWN**. I guess my candid response has to be that I am not in favor of it under the current cirmcumstances.

Judge **BONO**. My response would be the same. With respect to under the current circumstances, 120 days would seem to be overly restricted.

Chairman **PICKLE**. Could you submit to us for further analysis how you arrive at that conclusion; I want to get a reaction from you.

Mr. **SEIBERLING**. Mr. Chairman, would it be in order to ask just one question of the judge?

Mr. **ROUSSELOT**. If you don't, I will.

Mr. **SEIBERLING**. If this bill became law, if that would help encourage the administration to provide a sufficient number of judges and staff, so that the appeal would not have to run beyond 120 days?

Judge **BONO**. I would reply to that question by saying, it would give them the greatest motivation to do so.

Mr. **SEIBERLING**. Thank you.

Mr. **ROUSSELOT**. Mr. Chairman.

Chairman **PICKLE**. Are there questions by my colleagues?

Mr. Rousselot.

Mr. **ROUSSELOT**. You mention that other benefit programs do have time limits applied, food stamps, which is currently a very large program, and aid to families with dependent children. What are those limitations, and are they similar to the ones you are recommending?

Mr. **SEIBERLING**. Frankly, Mr. Chairman, I don't recall what the exact time limits are, but it is a very good question. I will be glad to take that up and supply it.

Mr. **ROUSSELOT**. I wonder if the adminstrative law judges can comment. Do you know about the limitations set on these other two programs, and if they have limitations, why couldn't you comply with similar ones?

Judge **BROWN**. I would say that we have our hands occupied taking care of our own disability programs, and I don't know what those requirements are.

Mr. **ROUSSELOT**. You have never looked at the limitations that are applied to those programs, and how they meet those deadlines if they are mandated?

Judge **BROWN**. We have not looked at them.

Mr. **SEIBERLING**. Would the gentleman yield?

Mr. **ROUSSELOT**. I will be happy to.

Mr. **SEIBERLING**. My staff informs me that it is 45 days for aid to families with dependent children, and 15 days for food stamps.

Mr. **ROUSSELOT**. How can they meet those mandates, and you can't?

Judge **BROWN**. I think there are some different issues that are involved, and in making the determination of disability, for example, which is chiefly the subject area that we are talking about, I think the most direct answer, there are other considerations.

Mr. **ROUSSELOT**. You mean that disability takes a lot longer to consider?

Judge **Brown**. Yes; because there may be evidence that is outstanding, which we have to request. We are dependent on doctors and hospitals. When we have to ask the consultant for studies to clarify the nature or the extent of the impairment, we have to go to the State agencies and ask them to do that work for us, and there is time lost in doing that. There are many considerations.

For one thing, you have to give a claimant 10 days notice for him to be ready to come to a hearing, so you have 10 days right off the bat. I would say that some cases, if the docket is current, that can be heard between 1 and 2 months of the time that the person asks for the hearing. It takes some time for the request for a hearing and the claimant's file to get to us. That is also a delay factor in given situations.

Mr. **Rousselot**. I have not yet gone through your statements, but I am sure you have given us some recommendations on how to solve that.

Judge **Brown**. Principally, we are addressing the issues that were in the press release, and primarily on the issue of difference in standards.

Chairman **Pickle**. The Chair would observe to Mr. Seiberling, as I understand it, the administration would suggest a limit of 165 days, instead of 120 days. So there is a recognition that there is a time factor.

Of course, there is reason to assume that it would take a longer time in the case of disability because the heart of that is the medical evidence that must be studied and analyzed. At least we are pursuing this problem and there is going to be some kind of a reasonable time limit either by legislation or by administration rules that should be followed to get these cases settled.

Mr. **Seiberling**. Would the chairman yield?

Chairman **Pickle**. Yes.

Mr. **Seiberling**. The 165 days is about what the national average is. I would like to point out that in many districts, the Cleveland office, for example, they are way beyond that time. The adminstration is simply not complying with its own time limitation.

But if it is going to cost them money by paying benefits if they ran beyond a particular time, then I think that would sharpen their concentration considerably, to borrow Sam Johnson's analogy, and they would begin to see that these cases were decided within the time limits.

Chairman **Pickle**. I would say that your legislation has caught their attention. We thank you very much.

Mr. **Seiberling**. Thank you very much.

[The following letter was subsequently received:

Congreſs of the United States
House of Representatives
Washington, D.C. 20515

November 16, 1981

Hon. J.J. Pickle
CHAIRMAN
Social Security Subcommittee
Committee on Ways and Means
A522 HOB Annex 1

Dear Jake:

As you know, I testified before your Subcommittee on my bill (HR 4775) to impose mandatory time limits on processing social security claims. As you recall, one provision of my bill recommends that hearings and appeals decisions for cessation orders be made within 60 days, since the cessation of benefits imposes severe hardship on individuals who have no other benefits available to them. As you know, 70% of cessation orders are reversed on appeal. In view of the large number of cases that are reversed, it is imperative that timely decisions be made on appeals from cessation orders, since, from the time of the cessation order until the final decision, disabled persons cannot receive any of the benefits in question. I also recommend that reconsideration decisions be made within 90 days.

I just learned about a tragic case involving one of my constituents which brought home to me most poignantly the dimensions of suffering which accompany the bureaucratic delays in the Social Security Administration.

In May of this year, I was contacted by this constituent who had just been notified by the Social Security Administration that his social security disability benefits were being terminated. He had been receiving benefits for six years after he was determined permanently disabled with severe coronary artery disease. The notification from SSA stated that review of his file supported a finding that he had "the physical capacity to perform a full range of medium work and could do past work as a truck driver." My constituent disagreed, and requested my assistance to restore his benefits.

The reconsideration process took nearly six months to complete. During the six month period, my constituent had little income to support his family, so, on November 2, with continued uncertainty about when he would hear from SSA about his claim, he returned to work contrary to the advice of his physician. Five days later, on November 6, he died of a heart attack. Three days later, on November 9, my office received word that the cessation order had been reversed, and that his benefits would be restored retroactive to the date of cessation.

This tragedy didn't have to happen. Unfortunately, given the present state of the economy, and the unconscionable delays experienced in processing social security claims, this case is probably not unique. Nearly every case that comes to my office involving cessation of disability benefits takes anywhere between nine and fifteen months to process.

Mr. Chairman, I urge you to take prompt action on legislation to impose time limits on processing social security claims. I believe it's the most immediate way to solve the problem of lengthy delays. The burden these delays are imposing falls on the most helpless of our citizens, the disabled. I believe the situation calls for swift action to assure that persons who have paid into social security receive timely decisions on their claims for benefits when they become disabled.

Warmest regards,

Sincerely,

JOHN F. SEIBERLING
Member of Congress

JFS:sg

Chairman PICKLE. Now the Chair would ask if the staff attorneys for the Office of Hearings and Appeals would come forward, Dale Buchanan, vice president; and Mr. Jerry Resnick.

We have received your testimony, I presume, Mr. Buchanan, from you.

STATEMENT OF DALE BUCHANAN, VICE PRESIDENT, ASSOCIATION OF STAFF ATTORNEYS IN THE OFFICE OF HEARINGS, AND APPEALS; ACCOMPANIED BY JERRY RESNICK, STAFF ATTORNEY, OFFICE OF HEARINGS AND APPEALS, PROVIDENCE, R.I.

Mr. BUCHANAN. Mr. Chairman, and members of the subcommittee, I appreciate the opportunity to appear before you today, and present the position of the Association of Staff Attorneys of the Office of Hearings and Appeals concerning the current hearing backlog facing the Office of Hearings and Appeals.

I have been a staff attorney with the Office of Hearings and Appeals since August of 1975. I am currently assigned to the Chattanooga, Tenn., hearing office.

I have filed a written copy of my testimony with the subcommittee, and I will base my testimony upon that document.

I am accompanied today by Mr. Jerry Resnick, an attorney adviser with the Providence, R.I., hearing office, who will speak briefly on his own behalf from his experience as an attorney adviser with the Office of Hearings and Appeals.

The staff attorneys support program was initiated in the Bureau of Hearings and Appeals in August of 1975, in the face of a backlog of slightly more than 100,000 cases, to be more exactly, 107,000 cases. The initial group of some 200 attorneys, with temporary appointments, helped bring about a substantial reduction of that backlog. After assisting in producing quality disability decision in a greater volume than ever before seen within the agency, the group was rewarded by being made permanent employees in January of 1977.

The delegation of many of the Administrative Law Judges' duties of decision writing, legal research of complex issues, and giving expert and competent legal advice, has enabled the corps of Administrative Law Judges to more than double the number of cases adjudicated by each judge.

In the several years since the inception of the staff attorney support program, we have advised, supported, and acted in many cases as the alter ego of the Administrative Law Judges. We have proved over and over that our ever increasing expertise has been a valuable adjunct to the Administrative Law Judges in the hearing process.

Although rewarded with praise, the high productivity and loyalty of the staff attorneys has subsequently resulted only in frustration with the imposition of a career cap which inhibits any further advancement in Government service irrespective of merit.

To use my own case as an example. After coming to the Office of Hearings and Appeals as a GS-11 with the first group of staff attorneys advisers in August of 1975 in Los Angeles, I was promoted to my ceiling of GS-12 1 year later. Thus, since the fall of 1976, a period of over 5 years, my colleagues and I have been frozen at the GS-12 level without any opportunity for career advancement.

During this time, we have participated in the adjudication of literally thousands of hearing decisions. Many of these cases have involved interpretations of complex issues of law and regulations, and a resolution of involved factual, procedural, jurisdictional, and evidentiary questions, the interpretation, evaluation, and weighing of highly technical medical reports and diagnoses.

Many have also involved the determination of statutory provisions on such issues as medical disability, residual functional capacity, insured status, the nature of income, legitimacy of children, interstate succession, conflicts of law as in the statutes governing corporations and taxes.

We have also been involved in the analysis, research, and decisional process in complex adversary part A medicare provided cases. We have drafted decisions of all levels of complexity. We have frequently had need to have direct communications with claimants or their representatives, and have held prehearing conferences with claimants and their attorneys.

Because of our extensive involvement at the hearing level of cases, we have become uniquely knowledgeable about the hearing process, and the requisites for according any claimant a fair and judicious hearing.

There is inequity in the fact that while attorney advisers in the Office of Hearings and Appeals have been and are limited to the grade of GS-12, it has been possible for a nonattorney hearing analyst to progress all the way to GS-14.

On the other hand, an appeal counsel analyst who happens to be an attorney, may reach the grade of a GS-14 as a supervisor, and assuming that the 7-year length of experience of criteria is met, could qualify for the Administrative Law Judges register under present OPM regulations. Meanwhile, an attorney adviser, who may be participating in decisions of greater scope and complexity, cannot qualify for the Administrative Law Judges register, whether he has 7 years or 17 years of experience.

In an affidavit dated October 18, 1980, and presented by Mr. Daniel Skoler, Deputy Associate Commissioner for Programs, in connection with the *McClure* case,[1] which was heard in the U.S.

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[1] *McClure et al.* v. *Harris*, U.S.D.C., N.D. Calif. (79-0201, CN, WHO).

District Court, Northern District of California, it was proposed that experienced attorney advisers be selected to conduct part B medicare hearings.

Mr. Skolar said in that affidavit:

> OHA attorney advisers presently perform a wide range of functions, including the evaluation and researching of procedural and evidentiary questions, interpretations, comparisons, and weighing of complex medical reports and findings, the application of involved statutory and regulatory provisions on such issues as medical disability, vocational incapacity, coverage and earnings formulas and requirements, and overpayment and refund findings and determinations involving social security claimants. They may be also involved in the analysis, research, and decision writing for complex, adversary, part A medicare provider cases, and assist in the disposition of these unusually time consuming cases. Such work intensively and professional pursued year in and year out under severe time pressures confronting OHA adjudication staff renders the experienced attorney advisers well qualified to conduct hearings in the relative small part B medicare claims which average approximately $200 per award.

In the *Blankenship* case,[2] which was heard in the U.S. District Court, Fourth District of Kentucky, which, as the members of this subcommittee know, deals with time limitations for due process decision processing, the administration again proposed that attorney advisers be utilized as hearing officers in a program generally patterned after the Federal magistrate system. Neither of these proposals has been implemented for reasons apparently not associated with the merits of the proposals, but the point to be made is that the Secretary in these two cases has expressly recognized the potential of staff attorneys who are already trained and who are prepared to become hearing officers without delay.

The latter proposals and others, such as the Government representative for adversary hearing experiment, have been dangled before the attorneys only to fade away before fruition.

Office of Hearings and Appeals is in danger of losing many of the most experienced, productive, and qualified staff attorneys as provision for professional growth is not forthcoming. Already many experienced attorneys have departed to private practice, or to other Federal agencies, having despaired of being able to progress within this agency.

One might ask why not more attorney advisers have not deserted the ship. The fact is that many of us feel that because of our uniquely qualifying experience in the analysis of medical and other aspects of social security legislation, we are serving the public interest in a noteworthy and beneficial manner by providing SSA claimants with a timely, well-written, factually accurate, and legally sound decision.

The honorable members of this subcommittee are well aware that many disability applicants are in dire physical, emotional, and financial straits by the time their cases are fully adjudicated. The professional satisfaction that goes along with attempting to aid in the expeditious due process handling of their cases is great.

This professional pride in what we are doing, and the optimistic belief that we will ultimately be afforded an opportunity to advance professionally is the bond that has made many of us stay in our currently unrealistically limited career level.

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[2] *Sammy Gail Blankenship et al.* v. *Secty H&HS*, U.S.D.C., M.D. Ky. (AC 75-0185-LA).

It is well known that the backlog of social security hearings is again reaching crisis proportions. The present backlog of more than 128,000 cases is the largest in history, and threatens to become even larger in the near future. Regardless of the cause of this backlog, and the causes are many, we feel that the presently utilized method of adjudicating these cases under the auspices of the Administrative Procedures Act remains valid, and we would not seek to bypass the Administrative Procedures Act as a means to the end of reducing the backlog.

It has been noted many times in recent years that the administrative law judges register, as administered by the Office of Personnel Management, has proven woefully inadequate in providing a sufficient number of administrative law judges to the Office of Hearings and Appeals.

OHA employs over 60 percent of Federal administrative law judges, a fact which makes the recruitment shortfall even more acute. The net increase in the number of administrative law judges from new recruitment after attrition in fiscal year 1980 was only 50 in spite of intensive recruitment efforts. I am quoting Daniel Skolar's affidavit on the corps.

The administration has predicted that under the present method of recruitment of administrative law judges, and full consideration of increased average disposition rates, the backlog is expected to grow rather than decrease, again using McClure as a background for this information.

It should be pointed out that once a new administrative law judge is recruited from the register, a significant training period is required. During this early period, the productivity and expertise of that new judge is relatively low, while he is trying to acquaint himself or herself with the applicable law and regulations, procedures, and other matters pertaining to holding a disability hearing, most particularly the complexities of making medical determinations in light of the Social Security Act.

The regulations require that claimants must prove their disability on the basis of medical evidence, with the further legislative requirement that the disability must be demonstrable by laboratory analysis and diagnostic techniques. The experienced staff attorney, who already possesses this expertise, could be employed immediately in deciding cases.

As stated before, OPM regulations presently require 7 years of qualifying experience of which 2 years must be in actual involvement in administrative law or trial proceedings. It has been determined by OPM that the work of an attorney adviser would be considered qualifying in terms of experience requirements. However, the experience of an attorney adviser has been stated by OPM to not meet the requirements with regard to the level of experience.

Thus, as I pointed out earlier, the attorney advisers are presently barred from any opportunity to gain the level of qualifying experience described in announcement 318, unless we go outside the agency to do work which is not necessarily related to disability adjudication.

The subcommittee has been provided with several proposals of avenues by which attorney advisers could be provided with a career ladders of GS-13 and 14 to ultimately meet the level of experience requirements for the ALJ register. The Association of Staff Attorneys has not adopted any of these specific proposals as an official position, since our members feel that APA guarantees of decision independence and due process for the claimant would be difficult to achieve where the hearing officer does not have full APA protection.

We respectfully suggest that the experience staff attorneys of the Office of Hearings and Appeals, who would otherwise be qualified, be recognized and deemed to have met the level of experience requirements for the interim purposes of qualification for the ALJ register.

The application and examination procedure is a long-time consuming ordeal. This fact would preclude the recruitment of a substantial of hearing officers in the shorter leadtime required by this method. Thus, in the interim, GS-12 staff attorneys with 4 or more years of satisfactory experience within the agency could be selectively appointed for a 2-year term as temporary administrative law judges at the grade of GS-14 in line with the emergency nature of the evolving critical situation.

This 2-year term as a temporary administrative law judges should be deemed in the enabling legislation to meet the level of experience requirements for the purpose of appointment to the ALJ register.

This association is well aware that the solution is of a temporary nature, and that previous legislation of a similar nature has not provided a permanent solution. A follow-on program, which would provide a continuous supply of qualified hearing officers should be initiated simultaneously.

This program could take the form of a magistrate type of program, providing grades of GS-13 and GS-14 in which less qualified, but still well qualified, attorney advisers could hold hearings and issue decisions upon nonwaiver of a hearing before administrative law judge.

We reemphasize, in relation to the latter proposal, that there be a guarantee built into such a program. The resources available in the form of experienced qualified staff attorneys should not be allowed to dissipate due to the frustration cause by an unconscionable lack of opportunity for advancement.

The history of loyalty and dedication and productivity and expertise within this group should no longer be ignored in the face of the crisis facing our agency now and in the future.

We have demonstrated our professionalism and competency over the years, and we earnestly seek your support in enabling us to lend our aid in the present crisis in the manner for which we are uniquely qualified.

Thank you. I will be more than happy to answer any questions at this time.

Chairman PICKLE. Thank you, Mr. Buchanan.

You do not recommend a deviation on the Administrative Procedure Act in selecting the administrative law judges, but rather you would recommend that the procedure be amended to allow a section of staff attorneys who have given 4 years of reasonable and proven experience to be appoined as a temportary ALJ. Is that the essence of what you are recommending?

Mr. BUCHANAN. That is correct, Mr. Chairman.

Chairman PICKLE. Thank you very much.

Mr. Shannon, do you have any questions?

Mr. SHANNON. The question that I had was fairly well covered in your testimony, Mr. Buchanan.

I guess it is easy to see how somebody with experience in the system might take less training time, and would be more efficient than a new administrative law judge.

What about the morale aspect of this. You became a GS-12 in 1976, 1 year after entering the service, and you have been there ever since.

Mr. BUCHANAN. That is correct.

Congressman Shannon, as I pointed out in my testimony, there are many other factors which have kept me with this agency, in spite of the fact that I know that myself and many of my colleagues probably could be making more money, and could be successful in private practice, or in other agencies.

But we do feel that with our unique qualifying experience that we have given a great deal of aid to this administration in a problem which surfaced before we were hired, and continues to exist at the present time.

As to the morale aspect of this, there certainly has been an effect. We have lost a lot of qualified staff attorneys. I know of several who have gone into private practice, and are now representing social security claimants before the administrative law judges. So it has definitely had an effect on the corps and the supply of experienced attorneys.

Also along that line, there are movements which have surfaced recently which stand to denigrate the position of the attorney adviser to the point where our position has been assessed, or will be assessed in terms of performance evaluations purely on a quantitative measurement, to the denigration of the rest of the functions of our position.

Our position description contains nine functions, all of which are professional, and all of which pertain to the qualifications of an attorney. Only one of these has to do with a quantitative measure, but this is going to be reduced to a performance standard. These are the types of things that we feel are affecting the morale as well as the lack of promotional opportunity, and the opportunity to become a hearing officer.

Mr. SHANNON. We will all do the best we can to help.

Mr. BUCHANAN. Thank you.

Mr. SHANNON. Thank you very much.

Mr. HEFTEL. Do we have a statement from the Office of Personnel Management on the issue of the staff attorneys that they are not qualified with their experience to be considered for an administrative law judge applicant?

Mr. BUCHANAN. Congressman Heftel, I brought with me a statement which one of our staff attorneys received in response to his query on that point. He requested information from the Office of Personnel Management as to whether his experience would meet the level of qualification. He received a response stating that our experience did not meet the length of experience for purposes of the APA due to the fact that we have been prevented from serving 2 years at the GS-14 level.

Mr. HEFTEL. It doesn't make sense. If you are in a position of management, you try to solve these types of problems so that you get sufficient effective results in your personnel. What we seem to have here has no explanation. It shows a lack of ability to maximize its own personnel.

Mr. Chairman, I would be interested in both testimony and statements from the Office of Personnel Management on why they think this is not good management.

Chairman PICKLE. If you will yield.

It is the Chair's intention at some future hearing to have the Office of Personnel Management before our committee, so that we can ask some of these questions.

Mr. HEFTEL. Because these are the people that we really need, and what we are hearing doesn't make any sense.

Thank you very much, Mr. Chairman.

Chairman PICKLE. I thank you, Mr. Buchanan, for your testimony.

Now the Chair is going to deviate a little from the schedule and ask our fomer colleague, Mr. William J. Randall, if he would make his statement at this time.

STATEMENT OF WILLIAM J. RANDALL, INDEPENDENCE, MO. (FORMER MEMBER OF CONGRESS)

Mr. RANDALL. We appreciate your putting us on at the last minute. We are very grateful. We did that as a backup witness in case some of our witnesses were not able to be present. But they are here.

However, I believe we might be able to make a contribution with a prepared statement, and I will ask for about 10 days or 2 weeks in which to prepare a statement to include in the record.

[The prepared statement follows:]

Statement of William J. Randall, Former Member of Congress, From the State of Missouri, 1959-77

Mr. Chairman and members of the subcommittee on social security: My name is William J. Randall. I reside in Independence, Missouri. I was a member of the United States House of Representatives for nine terms from 1959-77.

On Wednesday, October 28th I was listed as a witness. I requested that listing at the conclusion of the first hearing on Friday, October 23rd.

Mr. Chairman, my attendance at the hearing on Friday 23, 1981 in the Main Hearing Room of Ways and Means in the Longworth Building was almost wholly by accident. I was in the City of Washington on other business. I sort of stumbled on to the schedule of hearings when I noticed in one of the Congressional Offices a copy of your press release on these hearings. It was after I was able to listen to the testimony of Associate Commissioner Louis B. Hays that I became determined to try to make a contribution either as a witness or for the record.

Before I proceed further let me establish for the Subcommittee that I have no axe to grind. I have a small practice in the Kansas City, Missouri Area. I do not specialize in disability cases. I have handled only one (1) in the four years since I retired from Congress to enter private practice.

Most of my testimony will be based on the recollection of the hundreds of constituent disability cases that came across my desk in the 18 years of my membership in the House.

As a basic premise I hope all are in agreement that disability applicants must be very carefully evaluated at all levels to be sure and certain that there is a true and genuine disability and not some planned, studious and subjective imitation of disability by the applicant.

During the years of my Congressional service the Social Security Administration seemed to adopt the philosophy that they had no other recourse—that they simply had to deny a very high percentage of applications. I remember a statement by one Commissioner that denials were absolutely necessary or else everyone in America would sonner or later be on Social Security Disability.

While my memory cannot recall all of the details of those countless cases, I do retain the clear impression that many meritorious applicants seem to have been almost summarily denied.

Mr. Chairman, I have had the opportunity to go over the testimony of Commissioner Hays, given on October 23rd, and I made notes of the questions asked by the Committee members. I have also reviewed the testimony of the other witnesses who appeared on Wednesday, October 28th. My testimony will be supplemental and perhaps differing from the views of the Commissioner and some of the other witnesses, as follows:

There is no doubt that there is a considerable backlog of cases to be heard by the Administrative Law Judges in the Office of Hearings and Appeals. Some of the witnesses testified that the appeals process must surely be in error in 60 percent of the decisions at the State Agency level are reversed. On the other hand, State Agency officials contended the decisions which they entered were more than 90 percent accurate. After listening to such strong allegations I looked in vain for any disclosure by the State Agency witnesses of any method by which they compiled their statistics. Rather than point the accusing finger at the "Appeals System" without any analysis of their statistics creates a suspicion which would justify a long and careful look to see whether in fact something may be going wrong at the State Agency determination level.

In my notes I find that a representative of the National Association of Disability Examiners testified that State Agencies "need to be relieved from time requirements placed on them . . . . because such prevents them from developing cases properly." This should argue strongly that a full and fair consideration is not always given to a claimant's application until it reaches the appeals level before an Administrative Law Judge whom we all hope will always be given the latitude to develop the facts in each case properly without working under time orders.

If my hearing was good—I though I heard one of the witnesses for the Administrative Law Judges testify that the Judges fear the appeals system may become a sort of "dumping ground" for the hurried State Agency process. I hope the Subcommittee will recognize that if the evidence in each case is not properly at the State Agency level it is not a good, equitable, fair or just solution to force the Appeals Judges to accept the hurried and thus incorrectly prepared cases coming up to them from the lower level.

The argument which is based on invalid statistics to blame the Administrative Law Judges for the increasing number of allowances or approvals at the appeals level is patently fallacious. Such an argument ignores the real problem. It is not a constructive kind of argument. It ignores the proposition that a fair decisional process should be achieved at the earliest point in the decisional process.

Representatives of the States Agency Association testified that if the Administrative Law Judges are reversing 60% of the decisions made at the State Agency level their conclusions was that something must be wrong with the Judges. No reference or mention is even whispered that the State Agencies have been using policy manuals that are inconsistent with Social Security Law to control their decision making process at the lower level.

Members of this Subcommittee will note, I hope, that a situation prevails where if a claimant does not have the means or the where-withall to pursue an appeal to the Judges level, he has no remaining recourse but to accept the application of policies that may or may not be in accordance with Social Security Law. I submit to the Subcommittee, such a condition or situation is intolerable.

Well, what is the solution to the disparity of allowance or approval rates between the lower level State Agencies and the level of the Administrative Law Judges. One clear solution is that the lower level process be required to abide by the decisions of the appellate judicial bodies—which means the lower level process must develop its cases more adequately. Such a course is more in keeping with our traditions of American judisprudence and is far and away more fair and preferable that the suggestion that any lower level guidelines should somehow be binding on the Judges.

It is my carefully considered judgment that no solution to the backlog in the office of hearings and appeals will ever be reached so long as the appeals system has no authority or power over the lower levels of decision making. If an appeals system is even partly controlled by the agency whose cases are judged—then the process becomes an appeals system in name only.

It is my recommendation that thought should be given to the removal of the Office of Hearings and Appeals from the Social Security Administration and placed in a truly independent system with the objective that due process will not be hindered by either fiscal consideration or management interference by an agency whose missions is certainly not judicial.

This Subcommittee should give careful attention to the several sources of testimony already made a part of this record which serve as a clear alarm that a due process system that touches the lives of so many Americans should not be oppressed by organizational pressures and policy dictates that are inconsistent with both the Social Security Law and the Administrative Procedures Act.

Before I close this statement for the record I hope I may voice my sincere plea that this Subcommittee never agree to a change that will permit the determination of severity of impairment to be based on some kind of "average man" concept. Each case should be decided on the evidence. Any effort to create uniformity of decision by the so-called "Grid" limits entitlement for Title II and Title XVI benefits to only those who can be pigeon-holed into requirements for residual functional capacity to engage in substantial gainful activity. The Judges must not be denied the right to hear the case "de novo" otherwise either the claimant or the Social Security Administration may be denied due process.

Finally, if my hearing did not play some kind of trick on me, I thought I heard Commissioner Hays in response to a question from one of the members of the Subcommittee on Friday, October 23 state that with improved word processing and Administrative Law Judge should be able to decide 55 cases per month. This kind of suggestion scares me. Any suggestion that an Administrative Law Judge ought or must decide any certain number of cases per month is fixing a quota which denies independence. This means if a Judge does not decide such a number of cases he will be disciplined. Such a suggestion destroys the image of a Judge in the eyes of the public—worse, it abuses a vulnerable citizenry.

Courts must never become the agents of an agency. The caliber of the Administrative Law Judges must be maintained. The constitutionality of a quota system is very suspect because the due process rights of the needy should not be destroyed.

Mr. Justice Holes once said "justice delayed is justice denied". As I close I respectfully point out to this Subcommittee, justice by quota is justice denied. Decision based on a hurried process with incomplete evidence would be a sorry solution to our problems. It would be no justice at all.

Chairman **Pickle**. We will be glad to have your testimony, and the testimony of your people.

Mr. Randall is one of our very distinguished former colleagues, who was around here longer than almost anyone. We spent some very pleasant days with you in days gone by.

Now the Chair will ask that Mr. Carroll D. Moore, representing the National Association of Disability Examiners, come to the witness table. Mr. Moore is accompanied by Mr. Marty Blum, legislative chairperson.

Mr. **Moore**. That is correct.

Chairman **Pickle**. Mr. Moore, if you would take a seat at the table, we will be glad to receive your testimony. Let me ask that you summarize your statement. We have three other groups to follow, so we must ask you to summarize your testimony, and then your entire statement will be included in the record. We may submit additional questions in writing.

STATEMENT OF CARROLL D. MOORE, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY MARTY BLUM, LEGISLATIVE CHAIRPERSON

Mr. **Moore**. Thank you, Mr. Chairman.

Again, for the benefit of the full subcommittee, my name is Carroll Moore. I represent the National Association of Disability Examiners. Sitting to my right is Mr. Marty Blum, who is a former president of our association, and presently serves as the legislative committee chairperson.

Inasmuch as the subcommittee already has our written comments for this hearing, what we will do is summarize the information that we have submitted. I would like to say that we are commenting on four areas. We have restricted our comments to those four areas, and I would like to notice each of those at least in brief summary.

We are concerned about the continuing disparity in the adjudicative standards that are used between the different administrative levels. We are concerned because those in the State DDS's are adjudicating cases on the basis of the information contained in the POMS, and that has already been brought out here this morning.

The case then gets to the appeals level of the OHA, and many times at that particular level the decision that has been made based on the criteria that has been followed at the State agency, for both an initial and a reconsideration hearing, that decision is reversed because of the difference in criteria, also sometimes because of the difference in the time elements.

We believe that in the 26 years that the DDS has been in existence, and thousands and thousands of claims that have been adjudicated indicate without question that these cases have been adjudicated on the basis of objective evidence, demonstrable data, and the decision has been rendered as expeditiously as possible.

Whereas, when it gets to the ALJ level as has been cited this morning, about 60 percent of the claims are being reversed. I think there is some question on the part of the ALJ's pertaining to the word "reversed," but nevertheless the decision is reversed from a denial to an allowance.

We are concerned that there is a more lenient philosophy at the ALJ level which has now been recognized among the universe of disability claimants. If they do not get a favorable decision at the State agency, they are ready to appeal it all the way to the administrative level of OHA, or even beyond.

We want to make a point that there cannot be any logical basis for the increasing reversal rate of cases coming before adminstrative law judges while the State DDS's are adjudicating with an accuracy rate in excess of 90 percent, and in many States with an accuracy as high as 97 or 98 percent based on the criteria or the measurements set forth by social security.

We are also concerned about the wide variance in the reveral rates among the ALJ's. I call your attention to the fact that in several instances ALJ's are making reversals at a range from 10 percent all the way to 90 percent. They are not even playing by the same rules, we submit, even among themselves.

Another contributing factor is that the ALJ's are using a different standard for establishing residual functional capacity. They use a different form than the State DDS. They have access to getting an RFC from a different source than does the State DDS examiner. We believe that that creates problems, and we would like to see that issue addressed.

We call your attention to some proposals that we have.

First, we believe that congressional action is required to assure that all levels are guided by the same criteria. We endorse section 204 of H.R. 3207, and believe that that bill should be passed.

Second, we believe that the Social Security Administration should relax or revise processing timeframes that are presently imposed on DDS's, thus giving us more time to develop the case.

Third, we believe that further consideration should be given to having the administration represented at all social security hearings.

Fourth, we believe the own-motion review should be implemented.

Fifth, the RFC procedure should be applied uniformly among all the adminstrative levels within the administration.

Sixth, we believe that the proposed social security court is a good thing as is mentioned in H.R. 3865. We endorse that.

The second big issue that we want to address is the OHA backlog. We believe the very fact of the difference in philosophy is creating more appeals to the OHA level, and the more appeals, being understaffed as they are, the longer it takes for a decision to be rendered at that level. During that period of time, either the claimant's condition worsens sometimes, or the duration requirements then are met. So the ALJ at that level is adjudicating on the basis of information that is different than it was when the case was at the State DDS.

We propose two things on this particular problem.

First, if the OHA hearings process is permitted to continue as it is presently constituted, then the claimant who provides additional medical documentation on the claimed impairment for the hearing should have the case remanded to the DDS for additional review.

Second, where the claimant's allegations are based on additional impairments, or a worsening of the condition subsequent to the

DDS decision, the claimant should be required to submit a new claim for readjudication by the State DDS.

The third problem that we would like to address is the limited medical knowledge of the administrative law judges. I will not speak as long on this. I recognize and acknowledge that they are attorneys by profession, but the limited medical knowledge of ALJ's results in what we believe are requests for inappropriate medical documentation, and then when that documentation is obtained, improper assessment of the reported findings. We believe that the following should be undertaken:

First, the ALJ hearing should be solely on the basis of the record at the time of the reconsideration determination. No new evidence should be permitted.

Second, if the ALJ process continues as presently constituted, then the ALJ's should receive additional and ongoing training in medical factors.

The fourth issue that we would like to address is the OHA medical costs. As presently constituted, there is not any break out either in the OHA budget or in the State DDS budget on the amount of money expended to purchase ALJ documentation.

I cite there in the testimony different figures from States around the country. We are talking about a significant amount of money that is not known, it is not broken out. Neither the Congress, nor SSA, nor anyone else knows how much is being expended.

We propose that SSA should require the State agencies to report separately all the funds so spent; comparisons could then be made between States and regions, and figures for the national average of medical development costs per case at the ALJ level could be computed.

Mr. Chairman, and subcommittee members, the disability program is facing very serious problems of continued solvency and equitable adjudication of claims. Something must be done and soon. We commend you for your concerns. We believe the proposed legislation in H.R. 3207 and H.R. 3865 will improve the program.

Thank you, Mr. Chairman, and subcommittee members, for permitting our association the opportunity to testify, and we would be happy to attempt to answer questions.

[The prepared statement follows:]

STATEMENT OF CARROLL D. MOORE, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. Chairman and Members of the Subcommittee, on behalf of the members of the National Association of Disability Examiners, I welcome the opportunity to offer our views on the Social Security Appeals and Case Review Process.

The National Association of Disability Examiners has a membership composed primarily of employees in the state Disability Determination Sections who adjudicate Titles II and XVI disability claims for the Social Security Administration. It is from our unique perspective within the adjudication and appeals process that we offer our testimony.

DISPARITY IN ADJUDICATION

First, we are concerned and alarmed by the wide disparity in the adjudicative process between the state DDS' and the ALJ's; among the ALJ's themselves; and, finally, between the administrative levels and the Federal Courts.

By design of the program—its regulations, medical listings, and processing time goals—the state DDS disability examiner is limited in the interpretation and/or subjective opinion that can be exercised in arriving at a case decision. The disability examiner deals only with objective data consisting of medical records, laboratory and/or X-ray results, and nonmedical factors such as claimant's age, education and past work experience. Seldom does the disability examiner have face to face contact with the claimant, and thus does not have to resolve subjective opinions, emotional involvement with the claimant's well-being, family needs, or other such considerations. Historically, this has been considered one of the strengths of the disability program—purely objective adjudication on the basis of objective, demonstrable data, with the decision being rendered as expeditiously as possible.

On the other hand, the ALJ, not being bound by the same restraints, has been more at liberty to consider any and varied subjective factors such as claimant's appearance, financial need, family considerations, allegations of pain and other factors, as well as the medical findings. In recent years the ALJ has also heard a well rehearsed, more completely documented case due in large measure to attorney representation. The result has been a steadily rising reversal rate of DDS denied decisions when the case is appealed to OHA level. Currently as many as 60 percent of claims coming before ALJ's nationally are being reversed. This increasingly liberal trend compounds the problem by producing ever greater numbers of clients who when denied at the DDS reconsideration level then ask for an ALJ hearing. Presently the system is facing overwhelming complications due to the Accelerated Continuing Disability Investigation Process and the on-going periodic review mandated by the Disability Amendments of 1980. As the state DDS re-examines these cases and ceases many recipients based on improvement or not currently having a disabling condition, these persons, with greater frequency, are filing for a reconsideration, and if the cessation is affirmed, then asking for a hearing. The more lenient philosophy at the ALJ level is now an acknowledged fact among the universe of disability claimants.

How can there by any logical basis for the increasing reversal rate of cases coming before ALJ's while the state DDS' are adjudicating with an accuracy rate in excess of 90 percent, with many states having accuracy rates as high as 97 or 98 percent per Social Security measurements?

A further problem is the widespread variance in reversal rates among ALJ's. This phenomenon has been recognized by this Subcommittee, the Social Security Administration, the state DDS' and the public.

I cite a recent article in the Montana Great Falls Tribune of September 14, 1981. The chief ALJ for Montana, per this article, has a 74 percent reversal rate for the first seven months of 1981 compared to the national average of 55 percent and the eight state Denver regional average of 57 percent.

Other equally alarming figures of inconsistency in reversal rates of ALJ's can be cited. As an example, for calendar year 1979 in the Philadelphia region, of the ALJ's who rendered 200 or more individual decisions, the reversal rates ranged from a low of 12.5 percent to a high of 85.0 percent. Again in the Dallas region, for the six months period from November, 1978, through April, 1979, of the ALJ's who adjudicated 100 or more claims, the reversal rates ranged from a low of 19.0 percent to a high of 85.0 percent. Yet another example—in Lexington, Kentucky, I am informed that one ALJ has a fairly consistent statistical record of 10 percent reversal of DDS decisions whereas another has a reversal rate of 90 percent. Surely it becomes obvious that the ALJ's are not playing by the same rules, even among themselves!

Another contributing factor to the disparity in the administrative level decisions is the OHA practice of securing residual functional capacity (RFC) assessments in a different manner than state DDS' are instructed to do, and utilizing a special OHA RFC form which is different than that used by state DDS'.

The Social Security Administration instructs state DDS' that the RFC is the responsibility of the in-agency medical staff. Yet, OHA is free to obtain an RFC from any source they choose, as well as utilizing their own form.

I cite from a letter of March 3, 1981, written to the administrator of the California DDS by Mr. Sandy Crank, Associate Commissioner for Operational Policy and Procedures, SSA, which says:

"Social Security regulations 404.1546 and 416.946 provide that in cases where the state agency makes the determination, a state agency staff physician must assess RFC where it is required. These sections go on to provide that for cases at the hearing or Appeals Council (AC) level the responsibility for deciding RFC rests with the administrative law judge (ALJ) or the AC."

The letter continues, in the next paragraph:

"Recently issued OHA guides for ALJ case handling provide that when the ALJ finds he cannot make a decision as to RFC, but believes the record contains sufficient findings to enable a reviewing physician to do so, he or she should request the DDS to have a staff physician provide the assessment."

Finally, it is stated: "Irrespective of specific OHA policy guidance for ALJ adjudication, an individual ALJ may exercise his or her discretion by looking to a reporting medical source for RFC assessment."

Now, just so long as the OHA and AC levels are permitted to adjudicate by different standards, rules and regulations, just so long will the Congressional intent be violated and program integrity eroded.

During the past year SSA has begun a group of experiments known as Disability Appeals Reform (DARE), but as yet the final results of these experiments have not been reported nor actions implemented.

Our Association proposes the following as actions that should be taken to bring the various administrative levels into adjudicative harmony:

1. Congressional action is required to assure that all levels are guided by the same criteria. We commend the Subcommittee for your present efforts, and we endorse Section 204 of H.R. 3207 and believe it should be passed.
2. SSA should consider relaxing/revising processing time frames now imposed on DDS', thus providing more time for additional documentation and indepth investigation of all allegations of the claimant.
3. Further consideration should be given to having the Administration represented at all Social Security hearings.
4. The own-motion review should be implemented. This will provide a sample review of quality, accuracy and consistency of ALJ decisions.
5. The RFC procedure should be applied uniformly among all administrative levels with the Administration making further efforts to perfect a standard RFC form.
6. A Social Security Court, as proposed in H.R. 3865 should be established. We endorse this proposal. This would reduce the number of appeals levels; terminate the carrying of cases to Federal Court; and should prove more equitable.

OHA BACKLOG

Second, we submit that the OHA backlog produces many reversals of DDS decisions. The disparity of adjudicative procedures between the DDS and OHA creates heavier backlogs as claimants appeal their DDS reconsideration denial to OHA in hopes of obtaining a favorable decision. As more claims are appealed, the backlog increases; greater lengths of time occur before the hearing; and the claimant's condition may worsen, or the duration requirement is met, either of which situation results in a reversal of the DDS decision.

Some ALJ's seem to believe if the claimant is off from work for 12 months by the time of the hearing, then the claimant is obviously disabled and should be placed on the rolls, without consideration of the severity of the condition.

The backlog is also increasing due to the counsel of at least some attorneys who encourage claimants to not be totally cooperative with the DDS. In such instances, all medical evidence is not presented at the time of DDS initial or reconsideration level adjudication, but then is provided when the case comes to a hearing.

When the claimant receives a favorable decision at the ALJ level, the expressed belief is that the ALJ decision is right; the DDS was wrong. This is just not so! The time factor, a possible deterioration of the claimant's condition and/or additional impairments, as well as more medical documentation being available at the time of the hearing may drastically change the facts and circumstances.

We propose the following:

1. If the OHA hearings process is permitted to continue as at present, the claimant who provides additional medical documentation on the same impairments for the hearing should have the case remanded to the DDS for additional review. This would significantly decrease the OHA backlog while also giving the DDS an opportunity to consider the claim with the additional medical documentation.
2. Where the claimant's allegations are based on additional impairments or a worsening of the condition(s) subsequent to the DDS decision, the claimant should be required to file a new claim for re-adjudication by the DDS.

LIMITED MEDICAL KNOWLEDGE OF ALJ'S

Third, we believe the limited medical expertise of the ALJ's and their staffs frequently produce requests for inappropriate medical documentation, and improper assessment of reported findings. This produces allowances of claims contrary to SSA regulations and the medical listings. The ALJ's frequently request medical examinations and laboratory studies that are beyond the ability of the DDS to schedule, or that exceed in cost the ceiling imposed on the DDS' fee schedule. Requested studies are frequently viewed by the DDS as inappropriate to the correct investigation of the claimant's allegation. Yet, DDS' are instructed by SSA regional offices to not question ALJ requests. Again, ALJ requests for exotic studies and the additional time required for examination and preparation of the report by the consulting physician frequently cause such doctors to refuse to do examinations either for the ALJ's or the DDS'. The medical community does not understand the reasons for differences in reporting standards for the examinations.

We propose the following:

1. The ALJ hearing should be solely on the basis of the record at the time of the reconsideration determination. No new evidence should be permitted. Any further allegations of deterioration new problems, etc., should not enter into the hearing.
2. If, however, the ALJ process continues as presently constituted, then the ALJ's should receive additional and on-going training in medical factors.

REPORTING OHA MEDICAL COSTS

Fourth, present failure of the SSA to require separate reporting of funds expended by DDS' for ALJ development results in the medical costs of the OHA process being an unknown factor. There is not any line item reporting by DDS' of the amount specifically expended for either evidence of record or purchased examinations, X-rays and laboratory studies for ALJ's. Yet, here is a significant expenditure of funds that we believe should be reported. The Tennessee DDS allocates $144,000 annually for the purchase of ALJ medical documentation. In Texas, for fiscal year 1981, the funds expended by the DDS for ALJ medical requests totaled $238,299 for 2,702 cases, or an average of $90 per case. In the State of Mississippi for fiscal year 1981, total funds expended in this category were $69,729.

It is impossible for either the Social Security Administration or the Congress to have any factual knowledge of the amount of funds expended annually for ALJ medical deveopment. The OHA budget does not include any figure for this category of expenditures, since such expenses come out of DDS budgets. When a state over realizes case receipts, and budgeted money for medical development runs low, as it has in past years, the DDS' are required to cut back on the amount of medical purchases for their cases, while the ALJ requests for necessary, or unnecessary medical documentation, continues unrestricted.

We recommend the following:

1. If ALJ's are going to be permitted to continue development of additional medical documentation, then SSA should require a separate reporting of all funds so spent. Comparisons could then be made between states and regions and figure for the national average of medical development cost per case at the ALJ level could be computed.

SUMMARY

Mr. Chairman and Subcommittee Members, the disability program is facing very serious problems of continued solvency and equitable adjudication of claims. Something must be done—and soon! We commend you for your concerns. We believe the proposed legislation in H.R. 3207 and H.R. 3568 will improve the program. We hope you will give consideration to our testimony and the recommendation we have made.

This concludes our statement for the record. Thank you Mr. Chairman and Subcommittee Members for permitting our Association the opportunity to comment.

Chairman PICKLE. Thank you.

I particularly like your analysis, and then your recommendations. You don't wander all over the page. You make a summation and then a recommendation. I notice that you are following the outline of the bill that I proposed, H.R. 3207, so I would naturally like your testimony in general. You have given testimony to the point, and I thank you for it.

You state that we, the committee, should not impose processing time requirements, but the courts on some of the decisions are pushing us to pay benefits if certain limits have not been met. What will be the problems if we put these limits on?

Mr. MOORE. I am not so sure that I can address that relative to the courts, Mr. Chairman. I think that in order to have consistency within the program at the various administrative or adjudicative levels, there must be some type of basis established, some type of timeframes. I could not address how the courts may view that.

Chairman PICKLE. In one of your recommendations, you actually want to give more time.

Mr. MOORE. That was a proposal to the State agencies, yes.

Chairman PICKLE. You said you would consider relaxing and revising processing time goals.

Mr. MOORE. At the State DDS level.

Chairman PICKLE. Would that cause more delay?

Mr. MOORE. It would not cause more delay overall, I don't believe. We will have a chance to do more development, and perhaps prevent those cases from going on through the slow process of a hearing.

Chairman Pickle. In your testimony, you seem to endorse use of the POMS generally, and the bill that we have recommended would endorse the social security court concept, which you specifically recommend.

Mr. MOORE. Right.

Chairman PICKLE. Do you also endorse the statutory definition of pain and the provision that you would encourage medical school courses in evaluation of medical impairment, and continuing medical education.

Mr. MOORE. Let me address the last part of that first, if I may.

We definitely would endorse the medical school courses, the training. We think that that would be a very good thing primarily for the physicians.

Chairman PICKLE. I notice that you want training for the ALJ's.

Mr. MOORE. Not within the medical school setting.

Chairman PICKLE. No, but special training for them.

Mr. MOORE. We think that they or their staff, someone in their office needs to be better trained on medical factors. They need to have better medical knowledge than presently exists.

The other part of the question that you raised, I would like you to address that to me again.

Chairman PICKLE. Since you endorse generally the POMS and the social security court approach, would you also include that we have a statutory definition of pain?

Mr. MOORE. That is the difficult one.

Chairman PICKLE. I notice that Mr. Blum is itching to say something.

Mr. BLUM. A statement was made by one of the judges that talked about the subjectivity of the pain. Even without statutory definition of pain, there are enough guidelines in the existing POMS material to enable us to consider pain not strictly as a subjective phenomenon, but as it can be related very specifically to an impairment. The impairment must be demonstrated by objective findings.

So we are currently setting pain on the basis of the objective basis of it, and this is what we have been doing for years. I think the statutory definition would only strengthen what we have been doing. So I have no reservation to putting those guides into stronger statutory format.

Chairman PICKLE. The Chair now recognizes the other members if they have any questions.

Mr. JACOBS. Mr. Chairman, I had this question about the suggestion for medical schools having courses on evaluating medical disability. Are they going to do that, is that likely to happen?

Mr. MOORE. I think it certainly would be something that medical schools would begin to look at if this was something that was encouraged by legislation. The field of disability is getting to be a bigger field all the time.

Mr. JACOBS. How big is it in terms of all the doctors? Do you have any opinion about that?

Mr. MOORE. I don't have any figures. My opinion would be that it is a bigger part of their patient treatment than what may at first appear. I think the number of disability claims from across the country indicates that doctors are heavily involved in trying to assess disability on the part of their patients.

Mr. JACOBS. Do you think that there is some possibility that young medical students, looking forward to future practice, would be interested in taking a course in social security disability?

Can you get it done, that is what I am asking?

Mr. MOORE. Obviously, I cannot give you anything other than an opinion, but I believe that, yes, there would be a slow, gradual expansion of such courses and class size in various medical schools around the country.

Mr. JACOBS. Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Heftel.

Mr. HEFTEL. Do you gentlemen feel that attorneys in the practice of law have developed an expertise that is now identifiable in communities because of their ability to maximize the terms of the clients when they have substantial cases of disability, and this has become a case of a system deteriorating because the expertise of practicing attorneys is increasing, and the ability to counteract on our part is decreasing?

Mr. MOORE. I think that that situation is developing in metropolitan centers. In many large metropolitan areas, we are seeing a new type of legal practice, and that is representing disability clients at the ALJ level.

Mr. HEFTEL. You are saying, then, that we in the Congress and in this subcommittee should be concerned that we have been sufficiently innovative, that now the system can be exploited by a professional in the field of law who is taking advantage of the weaknesses, and perhaps capitalize on them for the benefit of the clients.

Mr. BLUM. I was going to add, coming from New York City, you see in newspapers attorneys advertise as specialists in this area of representing claimants for social security benefits.

I might add, tying this in with the problems of delay in processing, since the attorney does get a percentage. I believe, of the initial award, naturally as the case drags on and is delayed, and there is virtual activity for going back a year from the date of application, his award would be enhanced by the delay.

So there is sort of an incentive, I don't mean to present a cynical outlook, but I think we are all realistic, dollar and cents are often the bottom line in the business, and the attorney could receive a larger initial fee by the case dragging its way through the various appeals processes.

Mr. HEFTEL. I think, Mr. Chairman, this is important because we do believe that now the practice of law has learned how to capitalize in large income centers on social security disability programs, and we will find it being exploited to a greater degree. With the advent of advertising for attorneys around the country in radio and television commercials in which the attorneys will say, "If you have any kind of a problem, call us and we will figure out how to take care of it. You have rights that you should be able to sue on, and you may not know it."

Thank you, Mr. Chairman.

Mr. BLUM. I might add, just to dramatize that point, there was an attorney dealing with clients in New York who actually encourage their failure to cooperate on the reconsideration level, to get a denial on the reconsideration level, to get that before the ALF's, so again he would be able to represent the client, get a larger award, and show that he really earned it by helping him prosecute his case before the judge.

Chairman PICKLE. I think you made a very good point, Mr. Heftel, and I think we ought to look at it. I am distressed, as I said earlier, about why we have so many of these cases in appeal.

If I may make an observation, the ALJ's claim that the high reversal rate is because the State denial agency rated the cases in an unwarranted manner. Do you agree with that?

Mr. BLUM. No.

Chairman PICKLE. Do you want to comment on it?

Mr. BLUM. I certainly would vehemently disagree with that. Our denial rate has gone up, but we must recognize that social security sets the policies, the POMS, the framework with which we adjudicate. As they change their standards, and give us new guidance, we try to conform with that, and that guidance has been tougher. The standards have been tougher, therefore, our denial rate has been higher.

I might add, some years ago, and I have been with the program for 23 years and I have been to hearings and followed the happenings, and years ago I heard the argument that the State agencies were not documenting the files, and therefore the ALJ's were doing work which should have been done at the initial level.

I might add that some years ago there might have been more validity to that claim, but in recent years I think the documentation accuracy, if you would, of the State agencies has been much higher, as borne out by some of the statistics on Federal reviews. They call an error as a documentation error, and we have had fewer of those, so we are getting more documentation at the initial level. Again, the denial rate is because of the standards that have been changed.

Chairman PICKLE. So you don't agree with that?

Mr. BLUM. Not at all.

Chairman PICKLE. I thank you both, gentlemen, for your testimony, your entire statement will be included in the record. I want to compliment you on your testimony.

Now the Chair asks Mr. Rudolph Patterson, representing the National Organization of Social Security Claimants' Representatives.

If you will come forward, Mr. Patterson. Mr. Patterson, we are glad to have you with us. We will include your entire statement in the record, and you may summarize and proceed when you are ready.

STATEMENT OF RUDOLPH N. PATTERSON, VICE PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Mr. **Patterson**. Thank you, Mr. Chairman.

I am sorry that Congressman Heftel has left because I think I am one of those he is talking about. I am a private lawyer from Macon, Ga.

Chairman **Pickle**. I would not have known you were from the South, Mr. Patterson.

Mr. **Patterson**. The other fellow made his money and rose to his height owning peanut mills, and I started off shaking peanuts, so that tells you the difference between us.

Chairman **Pickle**. We will pass judgment after we have heard your testimony.

Mr. **Jacobs**. It is true, though, that you are no longer making peanuts, just eating them.

Mr. **Patterson**. I love them.

If I could, Mr. Chairman, since I have heard the testimony this morning, and I think probably getting to the questions and answers might provide more information for you than me just reading over the statement, let me just cover a couple of things for you briefly.

I would like to point out that based on the press release, we do wonder whether or not the backlog as it is referred to is, really, in fact, a backlog that should be of an alarming nature to anyone, or whether or not it is just an accumulation of cases based on the fact that we have more people, and more people are getting older, and more people are getting disabled, and maybe the staffing of the situation has not kept up with the population changes.

Also I think you will find in reviewing these cases that some of the things that have accentuated the increase in claims, as we refer to them, is the grid system. I think you will find that more people have been put on disability by the administration inventing what is referred to as the vocational guidelines, or the grids, because many times if you would check with the administrative law judges, you find people who are 55 years of age or older who, in the past, would have been terminated or who would have been denied benefits, but by virtue of the grids directing them to find that these people are disabled, they must put them on social security benefits.

I think also some of the things I have heard, some of the things I have read, and this also includes some of the things I read before I got here, and this is one of the reasons I wanted to come—all of the information I keep hearing is from people who have apparently never been before an administrative law judge trying to convince him that somebody without legs and without an arm is disabled.

Mr. **Jacobs**. They just don't look that mean.

Mr. **Patterson**. Everybody here today makes it sound like it is so easy. You walk in with a claimant, and a new medical report, and you walk out winning the case. It is not that easy. I can assure you that it is not that easy because we go in there, and we go in there with a case, and they ask: "What is this disparity? What is the problem between the OHA and the State agency?"

As a practicing attorney, let me give you some examples of the problems that we have. A part of the backlog, if you want to refer to it that way, that is occurring now is the terminations or cessations that are occurring. We wonder, from the people's standpoint, whether or not anybody had ever looked at any medical records before it gets to the OHA.

You get a case where they just decided, according to their rationale, that based on the medical that was in the file when you were put on benefits in 1974, it looks like you should have gotten well by now, so you are being terminated. There is not a new medical report in the whole file.

You get one, for example, that I recently had a hearing on, where the doctor, an internal medicine specialist, examined this person and said, "This is the same person I examined for you," talking to the State agency, the DDS, "in 1979, and found her disabled at that time. In reviewing and examining her this time, I find that she is more disabled now than she was in 1979," then she was terminated by the State agency because she was no longer disabled.

You have to wonder what is going on with the State agency. They keep talking about the ALJ's. I will tell you, I don't go before these soft-lipped, sweet-talking, stepping on marshmallow judges. The judges I go before are tough fellows.

I have been in this business for 15 years, and I have appeared before 100 administrative law judges all over this country, and I can tell you I have never run across what I thought was one who was willing to just give money without you producing a case.

I have run across situations where I wondered whether anybody at the State agency ever looked at the case before they signed their name to it saying that there was nothing wrong with that person.

Another problem that we run across in the handling of these cases that I have heard about is that they consider everything at the State agency level. I am particularly addressing myself now to the press release and most of the testimony I have heard this morning regarding the disparity between the administrative law judges and the State agency, and why there are so many reversals.

Another problem that we run across is they say that they consider the law and the regulations. Somebody asked about the definition of disability. Let me tell you, you read that definition, "that you have to be unable to engage in any substantial gainful employment that exists in the national economy by virtue of your impairment or the combination of your impairments, considering your age, education, and vocational experience," and you tell me that that is not a tough test.

Yet, when we get to the State agency report, they say that the absence of one leg is a nonsevere impairment. He could probably go sit down some place. Then the absence of one arm is nonsevere impairment, he can work someplace where all he had to do was pick up one thing at a time. The absence of his fingers on the other hand is not by itself an impairment.

The problem we run into—I don't know who makes the rules, but I have read over some of the POMS. Somebody told me that you could get a copy of them for $1,200, which is much more than peanuts, so I can't afford a copy of them. I have looked over them, and if you follow the POMS, and if you follow the sequential evaluation, and if you found a combination of impairments and then the rules on it, then we would have something that we could really compare.

But every case almost that I have handled, and I have handled several hundred of them, I find that the State agency handles each impairment on an individual basis. In fact, the forms that they have used would state, "Please consider the impairments individually, not in combination," which is in direct contradiction to the law and the regulations.

If you don't consider the whole man, how can you consider whether a person without one leg, and without one arm, and without one eye, if you don't consider all three of those impairments, how can you decide whether he is disabled or not. We submit this is part of the problem here, based on my conversations with the State agency people, based on the criteria, based on the rules and regulations that they apparently operate under.

They are probably 90-percent correct, but the question is, what are those rules. Are they outside of the POMS, or are there some other policies, are there some other unwritten accepted things that tells them what to do, or are there some of those things around that we don't have access to.

This you have to question as an attorney representing claimants when you see the type of medical evidence we see regarding some of your constituents, and wonder how can these people be denied at the first two levels.

An additional problem that we have is what they call the professional qualification, or PQ, that is included regarding the State agency position who is a reviewer. When you get that, all you know is that he was born in 1898, and was admitted to medical school in 1918, but what he has done other than that, you really don't know much about.

But you do know that you have a client who has a psychiatric problem, who has been in a psychiatric hospital five times, has tried to commit suicide two or three times, but yet they are categorized by the State agency psychiatrist as a person with a nonsevere problem.

I submit to you that everything I read before I got here, and everything I have read since I got here, and everything I have heard since I got here is an awful lot of dart throwing at administrative law judges, and nobody has really checked into what are the standards by which the State agency is being graded to come up with that 90-percent accuracy.

I could not do this, as I did not feel that ethically I could bring you a stack of State agency rationales because of the fact that we are bound by the right of privacy, and you can't just start passing out your client's medical information. But the problem that we run into is, why aren't they considering the entire individual, and then when we get to the ALJ, he does, and he does reverse it.

I brought an excerpt from the recent OHA reporter magazine, since this is a magazine that not everybody is entitled to, maybe Mr. Hays can get a copy of it for you, that recently contained the report from a former regional administrative law judge, Mr. Lassner, who stated that based on a study that was done in April of 1980, the Assistant Regional Commissioner, and the State agency people, or the disability program branch people, collaborated in a formal study to identify the basis for the differences between DDS and OHA, "Only cases reversed by ALJ's without a hearing were studied because in such cases the record before the ALJ was precisely the same as the record which was before the State agency."

Judge Lassner further states that:

> It became clear that the State agencies taking their cue from SSA's disability program branch viewed disability adjudication as being principally a medical matter, and relied heavily on the medical judgment of their staff physicians. ALJ's, on the other hand, view the process as a legal one, applying their interpretation of the law and the regulations with little regard for the opinions of the State Agency adjudicators, and little inclination to substitute their judgment for that of treating or consulting physicians when it comes to determining residual functional capacity.

Therein lies the problem. That is the problem in these cases as I see it based on a number of cases I have handled, and I have been fortunate enough to speak at seminars all over the country during the last 2 years and talked to attorneys, ALJ's staff attorneys, State agency people, and therein lies the problem that I have been confronted with all over the country, and that is, How can we as a State agency defend our position when we are bound to consider just the medical aspects of this person on a particular day, when a particular doctor was selected and examined this person on a particular day, and the person happened to be in pretty good shape that day? We have to find them nondisabled even though their personal physicians represent that they have more problems than that.

I submit to you that the biggest problem in this case is, as some of the previous speakers have indicated, that there is a double standard, but the double standard, so far as I know, is one that is really hard to pick out, and that is, where are the real guidelines that the State agency operates under, because there must be something different or we would not see the results in their reports that are so different.

If you say that you are only considering the individual impairment. You are not considering the combination. You are not considering the subjective complaints. You are only considering objective data. Then you are contrary to the law and the regulations, and the judges are sworn to unhold the law and the Constitution of this Country, and they are not just out there frivolously doing something.

There is one additional thing that I want to discuss with you briefly before I submit it. The own motion review thing, I think that is great. I think that it is great that you want to review things to see how things are going. As I read recently in a study, what agency is worth its salt if it cannot review what it is doing to determine whether it is doing good or bad.

But nobody has mentioned in this, the high affirmance judges. If they have got a judge who affirms 99 percent of his cases, they are not going to review his cases. They are going to leave him alone. He has been "doing a good job."

I submit to you, that is not the criteria in social security, that is not the criteria in any court of law I have ever been in, because the criteria is justice being done. It is a search of truth being met. The preponderance of the evidence in this case, or any other case, is to arrive at that one object of all legal discovery, and that is the truth.

Reference, as far as we are concerned, to any national average on allowance or denials should have little to do with the system of justice since each case must be considered on its own merits. An ALJ should not and cannot be concerned with his allowance or denial rate as it might be compared to the national average. If he did, I think he would be doing an injustice to his office because as everyone I have ever appeared before had to say, "It is my job to apply the law to the facts and the regulations. I am not here to make the facts. I don't make the law, and I don't make the regulations, but I have to apply the facts to the law and the regulations, and however it falls, it falls."

It may sound like I am here representing the administrative law judges, but as I sat here this morning listening to all this, it bothers me that we are not willing to accept what the real problem is, and the real problem is that nobody wants to talk about the whole man, mentally and physically. They want to talk about pieces of him, and say that pieces of him could do a job.

A lawyer in Wisconsin told me about a case he had to take all the way up to the circuit court of appeals before somebody would recognize that fact that the man did not have an arm, and as a consequence did have some impairment of hand-to-eye coordination. The circuit court of appeals finally recognized that without an arm, you did have some problem with hand-to-eye coordination. These types of cases exist.

As I said, I wish Mr. Heftel had not left because I would be happy to answer the questions that should be directed to a private attorney who doesn't work for the Government, who is not trying to go to work for the Government, who is not trying to get a promotion, as one person said, "because I have always worked for the Government." I have been here in the trenches representing the people, and have been since 1962 when I graduated from law school.

I will be happy to answer any questions regarding the alleged exploitation of the social security disability cases.

[The prepared statement follows:]

STATEMENT OF RUDOLPH N. PATTERSON, VICE PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Mr. Chairman, I appreciate the opportunity to appear before your Subcommittee to express my views on the hearings and appeals process of the Social Security Administration. For the past fifteen years, I have been engaged in the private practice of law as a partner in the firm of Westmoreland, Patterson and Moseley in Macon, Georgia. I have represented many hundreds of Title II and SSI claimants over these years. For the past two years, I have served as Vice-President of the National Organization of Social Security Claimants' Representatives.

I commend you and the members of your Subcommittee for conducting these hearings on October 23 and today. I would like to comment briefly on a number of issues.

The number of disability benefit awards has been on a steady upward climb since the inception of the program; however, that number, as a percentage of the population of insured workers, has remained fairly constant. There were 4.1 awards per

1,000 insured workers in 1980 and 4.0 awards per 1,000 insured workers in 1964 (the lowest point in the history of the program). What has changed dramatically is the level at which claims are awarded. In 1964, of the awards, 90.0 percent were made at the initial level, 7.5 percent were made at the reconsideration level, and 2.5 percent were made at the ALJ hearing level. In 1980, 69.5 percent of the awards were made at the initial level, 9.4 percent were made at the reconsideration level, and 21.0 percent were made at the ALJ hearing level. The rate of total state agency denials (initial and reconsideration) has been on a steady upward climb, from 50.5 percent in 1974 to 67.4 percent in 1980.

These statistics keep the current commentaries on the "too-high" ALJ reversal rates in perspective. It should be noted that as the denial rate of the state agencies rises, the ALJ allowance rate counterbalances it. As a result, the total awards for the past fifteen years of the disability program have remained fairly constant, when viewed as a percentage of the total insured population.

Concerns about the current ALJ allowance rate of approximately 55 percent persist. There are a range of explanations, most of which the Office of Hearings and Appeals recognized in their internal 1980 study (DARE 6). The data were drawn from a sample of 1,021 disability claims denied at reconsideration where a request for hearing was filed: 85 percent were initial entitlements, and 15 percent were cessations; 605 were ALJ reversals and 416 were ALJ affirmances.

In the study, state agency development was judged to be complete in 86 percent of the cases. These incompletely developed cases were more likely to be allowed later by ALJs. In fact, 17.4 percent of the ALJ allowance were those previously inadequately developed cases. The study notes that the evidence most frequently lacking included residual functional capacity evaluations or physical capacity evaluations, psychiatric/psychological information, various consultative examinations, and hospital records. Approximately 10 to 12 percent of cases adjudicated at the reconsideration level appeared to have had one or more file-documented impairments that were not mentioned in the evaluation.

In the study, the effect of the receipt of new evidence at the ALJ level was considered. Receipt of further medical evidence which provided new information on the claimants' impairments was present in 82.7 percent of the ALJ allowances. Documentation of a new impairment, or of a condition not alleged or medically indicated previously, appeared in 15.2 percent of the reversals; there was evidence of a worsening of condition in 31.2 percent of all reversals.

The study suggests the significant role of representatives, noting that claimants were represented in 65.5 percent of the cases in which ALJs awarded benefits and in only 50 percent of the cases in which they did not. Hearing decisions that noted or described an ALJs personal observation of the claimant represented 28.4 percent of the reversals and 37.5 percent of affirmations.

Interestingly, an "own-motion" review was conducted of this 1,021 sample. The Appeals Council agreed that for 3.3 percent of the entire sample (28 reversals and six affirmations), review would have been in order. The Council would have remanded 27 cases, and issued corrective orders in the other seven. Of these, the Council would have issued unfavorable decision in four that were allowed by the ALJ, would have issued partially favorable decisions in two that were allowed, and would have issued one partially favorable decision in a case not awarded by the ALJ.

The study is tangible evidence of beliefs long shared by claimants' attorneys: that medical information on new and/or worsening medical conditions, oral hearings, and effective representation account for a significant part of the difference between the decisions of state agencies and ALJs.

We are therefore concerned by the connotation of the words "reversal rates" used to describe ALJ allowance rates. Our experience is that ALJs are not duplicating the work of the disability examiners and "second-guessing" it; rather, they have more evidence in the file and the opportunity to hear testimony of the claimant, lay witnesses, and expert witnesses, creating an expanded record, and rendering a decision based on it.

The concerns that exist over the current ALJ allowance rate will be partially addressed by the on-going own-motion review, required under the Bellmon Amendment to the Disability Amendments of 1980. I have no argument with the Secretary's exercising his authority to conduct this review of ALJ decisions. However, the manner in which the Social Security Administration has chosen to implement it is of concern. It is unfair as well as statistically inaccurate to review only ALJ allowances of a selected group of ALJs. The statute requires a review of ALJ decisions, and does not narrow this mandate to only claimant-favorable ones.

Finally, I appreciate an opportunity to comment on the proposed government representative experiment. This is a costly undertaking which will turn the current backlog situation into a nightmare. It is a breach of a basic underpinning of the disability program to transform an informal administrative hearing into an adversarial proceeding. The Center for Administrative Justice discussed the adversary concept in its 1977 report and concluded: "We also reject the idea of counsel for the government, because we believe that an adversary posture runs contrary to the basic ideals of the Social Security system and does not provide overriding benefits in terms of the other quality dimensions of the system." The Social Security Administration's posture towards disability claimants has also been one of assistance in the interests of fact-finding, and should remain so.

Mr. Chairman, that concludes my remarks. I would be pleased to answer any questions that you or other members of the Subcommittee may have.

Mr. **Jacobs**. You said that perhaps it sounded as though you were representing the interests of the ALJ, and if I had to appear before them, I might say a kind work for them, too.

Mr. Shannon.

Mr. **Shannon**. I have no questions, Mr. Chairman. Thank you.

Mr. **Patterson**. They read everything you have said about them when you go up on appeal, and I am not always in agreement with them.

Mr. **Jacobs**. What is the principal cause for delay in hearings of this kind? Is it awaiting further testimony? Is it awaiting witnesses? What rights has a claimant's attorney for continuances, could you say a quick word about that, for the record?

Mr. **Patterson**. I will be more than happy to.

No. 1, we don't have that problem, apparently, in region IV. Please, leave us alone, because everything seems to be going contrary to the way you are all talking about it up here. I have had several case recently where my fee was less than $100 because they had been handled so quickly.

We get 25 percent of the award, and this means that my clients were getting a hearing, and a decision, and getting their first check within 6 to 7 months after filing. So we apparently don't have the problems that I am hearing about here today.

Mr. **Jacobs**. I guess that would be peanuts.

Mr. **Patterson**. The other question that you asked me. We find that really the judges are liberal in their agreement to a continuance as far as the attorney or the representative request might be, because you have to also realize that many people are represented by nonlawyers in these cases. Some of the paralegals are setting up, I understand, clinics where they will specialize in social security cases, and they are entitled to 25 percent, if it is approved.

To answer your question, I find that the judges, as long as it is not just for the purpose of delaying, if you give him a good reason, he is going to give you a continuance just like in a civil action case, or a criminal case, or anything else.

Mr. **Jacobs**. I hope that it is not like criminal cases because sometimes there are various reasons for continuance.

Mr. **Patterson**. We just have "cracker jack" lawyers in Georgia.

Mr. **Jacobs**. Do attorneys collect their fees; or have you run into that problem in Georgia?

Mr. **Patterson**. I thought that was a good reason for continuance.

Mr. **Jacobs**. We are now getting our definitions. [General laughter.]

Mr. **Patterson**. There is no real problem with that because I don't know of anybody that I have talked to that abuses that type of thing. This is not the first time I have heard that attorneys drag cases on to try to stretch it out so that they can get a bigger fee.

In fact, one of the district court judges in New York, when the case was finally resolved against the claimant, assessed the attorney's fees, and some expenses of litigation against the client's attorney for dragging it on when they found that they really did not have anything to go on.

Mr. **Jacobs**. Thank you very much for your testimony.

Our next witness in Mr. Burton D. Fretz, executive director of the National Senior Citizens Law Center.

STATEMENT OF BURTON D. FRETZ, EXECUTIVE DIRECTOR, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. **Fretz**. Thank you, Mr. Chairman.

The statement has been submitted, and I will keep my remarks brief, and simply address the highlights of the prepared testimony. That testimony was prepared by Ms. Eileen Sweeney of our program. Ms. Sweeney has just given birth to a baby boy and understandably is not able to be present before the subcommittee to testify in person. Consequently, I will just summarize some of the highlights.

We are appearing here on behalf of two groups of older Americans, the Legislative Council of Older Americans, which is based in Massachusetts, a membership organization of some 48,000 older persons, as well as the Gray Panthers, which is a nationwide organization of older persons having local chapters.

We have a number of concerns with the bill before the subcommittee, H.R. 3207, and I will try to mention those in passing, and then entertain any questions about them.

One of them has to do with the section of the subcommittee bill which would define or change the definition of pain to govern disability determinations. As we understand it, that definition in the bill is susceptible to a construction which would require some kind of clinical verification of pain as a premise to a finding of disability.

If that construction is a reasonable one, then we would submit that there are some important cases of individuals who are severely disabled by any commonsense account, nontheless whose pain is not always susceptible to clinical diagnosis.

What we have done for the subcommittee is to set out a half dozen of those examples with case citations that the staff can analyze in greater detail. I certainly submit that these are not the kinds of cases that the subcommittee members would want to exclude from disability, and yet there is that potential given the bill's definition of pain.

We also have some concerns with section 204 of the subcommittee bill, which would provide that rulings of the Administration, as well as the POMS would govern determinations of disability. Our difficulties with this, I think, arise from two points.

The first is its provision that SSA rulings and POMS material can be incorporated into operative bulletins and directives outside the Administrative Procedure Act and the act's very important provisions for public notice and opportunity for public comment. As most others in that regard, we think that the APA provisions in that regard have been very effective, and that it would be terribly unwise to permit working definitions to escape the public notice and comment provisions of the APA.

In addition, the POMS as well as the SSA rulings are not published and readily accessible to many advocates for older persons out in the field. Regulations, of course, appear in the Federal Register and in the Code of Federal Regulations, and are generally accessible.

What we fear from the import of section 204, Mr. Chairman, is that it could lead to the building up of a body of secret law which would not be readily understandable or accessible to all advocates. The word "secret" sounds a bit conspiratorial, and I certainly don't intend that connotation, but at least it sugggests the potential dangers of a reversion to a system in which operable definitions and standards are kept one or two steps removed from members of the public. We strenuously urge the subcommittee to take a look at that aspect of section 204.

We do support in principle the limiting provisions in the bill for own-motion review. We understand that the effect of the bill would be to codify the present practice, rather than to expand the scope of own-motion review. That is most appropriate.

There are some due process problems with what we see to be the current practice with respect to own-motion review, and we have spelled that our more particularly in the written testimony.

We also have some concerns with the separate bill, H.R. 3865, dealing with the social security court. We understand the subcommittee has not had opportunity fully to examine that. The limitations on review, the limitations on court access, and the dispensation with the Federal Rules of Civil Procedure for the social security court, all raise significant difficulties for it to be effective and fair. We have spelled those out as well in the written testimony.

I would like to emphasize one point. A good bit has been made, Mr. Chairman, of the need for uniformity and for bringing together the decisionmakers as it effects determinations of disability. Certainly, the goal of uniformity is a laudable one. All of us want to see people similarly situated treated in the same way.

A couple of policies within the Social Security Administration should be revisited and changed in order to assure greater uniformity in decisionmaking and to carry out the purposes that everybody agree on.

One of them involves the urging by the Social Security Administration of the preparation of a complete record prior to the time that it reaches the adminstrative law judge. I believe that Judge Brown alluded to that aspect in testimony earlier today. It certainly can be confirmed from our own understanding of what happens in practice.

All too often, when a representative enters the case at the point when it goes before an administrative law judge, the representative can look at the record and determine what vocational evidence or what medical evidence is needed and see that it gets into the record.

To the extent that the administration can promulgate rules to assure that such information is in the record in the first instance, and can monitor to assure that this is carried out would be cost effective. It would decrease the number of reversals, and probably decrease the total number of appeals as well. It would certainly encourage attention to that aspect of current Social Security Administration practice.

The other aspect that we think merits greater attention has to do with the administration's long-standing policy of nonacquiescence in court decisions which are adverse to the Social Security Administration. We have set out some instances in our testimony where this nonacquiescence policy has caused something of a patchwork of applicable standards, and really some inequitable results.

As we set out, there are instances where the United States Supreme Court invalidated one particular gender-based classification in social security law, and then reaffirmed that ruling in three subsequent cases. There were four United States Supreme Court rulings on that point, and yet only a very narrow class of individuals was permitted to avail itself of these rulings under Social Security Administration policy. It took a fifth one, a class action, to compel the Social Security Administration to observe the law with respect to the defined class of affected people.

We strongly urge that any and all arguments in favor of increasing uniformity of standards and decisionmaking be looked at carefully with one eye cast toward this whole policy based on nonacquiescence by the Social Security Administration. It is a problem which lends itself to remedy at the administrative level.

[The prepared statement follows:]

STATEMENT OF EILEEN P. SWEENEY AND BURTON D. FRETZ OF THE NATIONAL SENIOR CITIZENS LAW CENTER ON BEHALF OF THE GRAY PANTHERS AND THE LEGISLATIVE COUNCIL OF OLDER AMERICANS

I am Eileen P. Sweeney, a staff attorney at the National Senior Citizens Law Center (NSCLC), appearing on behalf of the Gray Panthers and the Legislative Council of Older Americans. We are most appreciative of the opportunity to appear before the Subcommittee today.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and the Administration on Aging. Pursuant to the Law Center's Legal Services Corporation grant, we provide support services to legal services attorneys throughout the country with respect to the legal problems of their elderly clients. Under the Administration on Aging grant, NSCLC will be providing training and planning assistance to the states, and we will be developing strategies to resolve the legal problems of older people without the direct delivery of services. My responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

The Gray Panthers is a non-profit organization incorporated in Pennsylvania, with its headquarters in Philadelphia. It has an estimated membership of 40,000 persons who reside throughout the United States. Its members seek to reform and improve various laws and institutions which affect the lives of the elderly, including Social Security and Supplemental Security Income.

The Legislative Council of Older Americans, Inc. is a statewide, non-profit organization representing approximately 48,000 senior citizens in Massachusetts. The Council's primary interests are income maintenance, health care and housing issues; issues which the Council advocates before the Massachusetts state legislature. The Council was founded in 1968 by its president, Frank J. Manning.

We believe that it is particularly important that the Subcommittee scheduled these hearings. There are numerous problems with the administrative procedures of the Social Security Administration which should be considered. Given the breadth of the topics listed for consideration at these hearings, we encourage the Subcommittee to hold additional hearings on particular issues, specifically, the Social Security Court proposal and the issues raised by that proposal.

Our testimony today will address a number of the issues raised by the Subcommittee. As a general matter, we believe it is necessary to stress a point often overlooked when the administrative procedures at SSA are discussed: the bottom-line should be the development of a system which assures high quality decisionmaking. As will be discussed, we do not believe that SSA has structured the system with an eye toward quality, or toward proper development of case files; nor has it properly complied with judicial decisions against it. Therefore, rather than supporting initiation of new review schemes and definitional limitations, we encourage this Subcommittee to closely scrutinize SSA's operations and consider what SSA could accomplish if it were required to comply with the law, rather than ignoring it as it frequently does.

(1) DISPARITY IN ADJUDICATION OF DISABILITY CASES AT THE VARIOUS LEVELS OF REVIEW

As noted in the hearing announcement, a substantial number of denials are reversed by administrative law judges (ALJs). We believe that this reversal rate results from the presentation of more complete records before ALJs, often due to the fact that the claimant has sought and obtained representation by an individual knowledgeable of the disability requirements and able to secure the medical and vocational records necessary for an ALJ to render an informed decision. Aside from some very general language, SSA has done nothing to require that state agencies assure that claimant's records are fully developed before decisions are rendered. It is common to discover that the state agency did little to assist the claimant in understanding the test and what evidence was required, much less assist in obtaining the evidence. It is rare that the agency will pursue a psychological impairment, despite evidence of the possible existence of such an impairment.

We are familiar with the state agencies' concerns that the resources available to them are inadequate to properly review all claims and, for purposes of this discussion, accept that as true. However, given the cost to SSA of both administrative hearings and further appeals, resources could be better allocated if tougher requirements were placed upon the state agencies and SSA itself to develop complete records at the initial and reconsideration levels. If necessary, the states should be provided with the additional resources to accomplish this task.

There should be no question that SSA has the authority to require such evidence development through its regulatory relationship with the state units, established in Public Law 96-265. However, given its unwillingness to pursue this approach, SSA should be specifically required to (1) implement rules requiring complete evidence development in every case and (2) establish a system for monitoring state and SSA personnel compliance with the requirement. We believe that a complete record is the basis for assuring uniformity of decisionmaking. Until SSA has implemented such a system, it is premature for this Subcommittee to be considering the procedural and definitional changes proposed in Part II of H.R. 3207.

(a) Definition of "pain" (H.R. 3207)

Section 205(a) of H.R. 3207, the "Social Security Amendments of 1981," would amend 42 U.S.C. §223(d)(5), adding the following:

"An individual's testimony as to pain or other symptoms shall not alone permit a determination that he or she is under a disability unless medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, show the existence of a medical condition that could reasonably by expected to produce such pain or symptoms."

We believe that one likely result of this provision will be to deny benefits to a group of severely disabled individuals whose unique situations prevent full and accurate documentation of their impairments. It is possible that the Secretary would not only deny new applicants but would also terminate the benefits of individuals already receiving disability where pain had been an important factor in the original determination of disability. Because we do not believe that many appearing before the Subcommittee will address this issue, we will do so in greater depth than other issues addressed here. In particular, we reviewed the case law in an effort to assess what effect the proposed definition of "pain" would have had if applied to various claimants' factual situations. As noted previously, while the definition will not affect the bast majority of cases, it may exclude from eligibility some severely disabled individuals. The cases discussed below illustrate the problem.

1. Mr. Underwood was in his 60's, and suffered from heart disease, lung disease, generalized arteriosclerosis, a disc condition in the lumbar region, and a possible severe aortal condition. He testified to general weakness, throbbing headaches, pain in the left chest, dizzy spells, and shortness of breath. Even moderate physical

exertion such as climbing stairs left him weak and short of breath. He suffered severe low back pain and cramps in the legs and arms. The Secretary denied benefits. The Fourth Circuit Court of Appeals reversed, *Underwood* v. *Ribicoff,* 298 F.2d 850, 854 (4th Cir. 1961), finding that "inadequate consideration [was given] to the possibility of severe orthopedic trouble. This is a physical defect that is notorious in medical circles for difficulty of clinical proof. . ."

2. Mrs. Twardesky worked for thirty years as a presser in dry cleaning plants, operating pressing machines and carrying and hanging large bundles of clothes. At age 47, she was operated on for repair of a large cysocele, a total abdominal hysterectomy and release of intestinal adhesions. She suffered lung complications. After returning to work, she was again operated on for repair of an incisional hernia in her lower abdomen. She had a history of Grave's disease (goiter) and suffered from a chronic lung condition. Her physician believed she was a poor risk for additional surgery due to her previous history of complications. Mrs. Twardesky testified that she became weak in the knees if she stood for long periods of time and experienced pain and numbness in her side if she sat too long. When she turned to the right, she experienced cramps across her chest and back. She also experienced pressure in the back of her head, which was only relieved when she laid down, and her stomach swelled every day. The vocational expert testified that, given her symptomology, she could not work. The Secretary disagreed and denied her benefits. The district court for the Western District of Pennsylvania reversed, *Twardesky* v. *Weinberger,* 408 F. Supp. 842 (W.D. Pa. 1976), finding that the Secretary improperly disregarded Mrs. Twardesky's symptomology as well as the vocational expert's testimony.

3. Mrs. Ber had been a sewing machine operator for thirty-five years. She suffered a slipped disc in her neck which was aggravated by an arthritic condition which she had had for nineteen years, all the time working, but which had worsened in the previous two years. She was then unable to work because of severe pains in her arms, head, and neck. She testified that the pain radiated out from her spine to her neck, head, arms, and legs, becoming so severe as to make even the use of eyeglasses most painful and requiring her to wear a cervicla collar and a prosthetic corset. She often slept the night in a chair due to her pain. She was often unable to hold objects in her hand. The Secretary rejected her claim for benefits, finding that the medical evidence did not support the findings of a severe impairment. The Second Circuit Court of Appeals reversed, *Ber* v. *Celebrezze,* 332 F.2d 293, 296 (2nd Cir. 1964), finding that "while the medical evidence may perhaps indicate that Mrs. Ber's physical symptoms were of a type which probably would have caused many people considerably less pain than Mrs. Ber suffered, it nevertheless amply supports her complaint that in her particular medical case these symptoms were accompanied by pain so very real to her and so intense as to disable her."

4. Mr. Catron suffered from parathyroid adenoma and recurrent bilateral renal calculi, poorly controlled hypertension, and rheumatoid arthritis of hips, knees, ankles, feet, heels, and the lumbar region. Physicians noted that he had considerable problems with his feet. Mr. Catron complained of severe pain related to both his arthritic and kidney conditions. The Secretary found that there was no medical basis for the degree of pain alleged by the plaintiff. Citing *Ber* v. *Celebrezze* 332 F.2d 293, 299 (2d Cir. 1964), the district court for the Eastern District of Virginia reversed, stating " 'pain unaccompanied by any objectively observable symptoms may be so real and so intense as to be disabling. . . ' " *Catron* v. *Weinberger,* 394 F.Supp. 10 1, 1014 (E.D. Va. 1975).

5. Mrs. Rosa was 61 years old when she applied for disability benefits. She worked for 24 years as a domestic worker, cafeteria worker and hospital housekeeper. At age 59, she underwent surgery for repair of an incisional vental hernia and was treated for a duodonel ulcer. Two months later, she was again hospitalized for an exploratory laparatomy and lysis of postoperative bowel adhesions. Within the next three months, she suffered upper gastrointestinal bleeding, and additional surgery was performed: a cholecystectomy and common duct exploration. Later, she had a cataract removed. The court noted that Mrs. Rosa "is the very antithesis of a malingerer" while listing her subjective complaints as noted by her physician: recurring bouts of dizziness occasioned by cerebral anoxia and bouts of incomplete intestinal obstruction secondary to adhesions. A second physician found she suffered from severe vertigo but stated that he believed her symptoms to be totally subjective. The district court for the Eastern District of New York reversed the Secretary's denial of benefits, finding that he had improperly refused to consider the subjective evidence, *Rosa* v. *Weinberger,* 391 F.Supp. 377 (E.D.N.Y. 1974).

6. Mr. Beavers was involved in a gunshot accident, leaving a bullet permanently lodged in his spine, and resulting in the removal of his left kidney and spleen. He also had metal clips in his spine as the result of surgery. While the doctors did not

agree on the ultimate severity of these problems, it was agreed he could no longer engage in manual labor due to the risk of dislodging the bullet and causing further damage. Mr. Beavers testified that he suffered pain in his back, legs, and head. He had been hospitalized on a number of occasions complaining of incapacitating back and leg pain and headaches. Medical tests were inconclusive but did establish that he had arthritis, degenerative disc disease and a severe curvature of the spine. Mr. Beavers could not sleep; his back and knees would lock rendering him immobile unless assisted; his legs numbed if he stood and he sometimes fell; he had to constantly shift his position in order to ease the pain; he wore a back brace when not in bed. The Secretary denied benefits. The Sixth Circuit Court of Appeals reversed, *Beavers* v. *Secretary of Health, Education and Welfare*, 577 F.2d 383 (6th Cir. 1978), holding that while it agreed with the Secretary that the medical evidence did not reveal a significant physical or mental impairment, the Secretary could not ignore Mr. Beaver's personal testimony regarding pain, as corroborated by his wife. It was incumbent upon the Secretary to determine the credibility of Mr. Beaver's statements. Here, the Appeals Council had reversed the ruling of the ALJ who had heard all of the testimony.

While it can be argued that many of these individuals should have been found eligible for benefits based upon their physical or mental impairments, the fact is that the Secretary denied each of these individuals. In each case, the courts relied upon the claimant's subjective symptomology in reversing the Secretary's decision. While in some of these cases it could be argued that the person would meet the "reasonableness" test of the proposed section, the Secretary certainly did not see such a nexus when denying their claims. Further, for those whose pain exceeds that found to be reasonably related to the impairment, benefits will be denied. Given the position taken by the Secretary in each of the cases above, it is likely that a statutory change would result in the judicial denial of benefits as well. As the proposed provision will not affect the vast majority of cases, where corroboration of subjective symptoms will exist, will create a great deal of confusion, and could exclude individuals such as those discussed above, we believe that the proposed section should not be passed.

(b) Guidelines for disability determinations (H.R. 3207)

Section 204 of H.R. 3207 would amend 42 U.S.C. 405(a) by adding:

"The regulations of the Secretary, and the Social Security Rulings and the adjudicative standards of Part 4 of the Program Operations Manual System (POMS) published under the authority of the Commission of Social Security, shall govern determinations of whether individuals are under disabilities as defined in sections 216(i) and 223(d)."

We do not believe that this provision should be enacted. It is critical that the disability determination process and the standards utilized therein be accessible to the public and subject to public comment. We therefore believe that the only binding rules should be those which are properly promulgated in accordance with the Administrative Procedure Act.

As will be discussed later, SSA's unauthorized practice of "non-acquiescing" in judicial decisions it disagrees with has effectively insulated it from fully complying with various court rulings, despite SSA's failure to appeal the decisions with which it disagreed. The Social Security Rulings, SSA's vehicle for "non-acquiescing," should not be accorded the weight suggested by the proposed provision. Rather, this Subcommittee should examine SSA's policy of "non-acquiescence" and consider its appropriateness in the overall administrative review scheme. As noted later, we believe SSA should be prohibited from disregarding judicial decisions.

Similarly, changes in the POMS are not issued for public comment. The effect of Section 204 will be to encourage SSA to avoid the regulatory process, just amending the POMS. We are already seeing a tendency at SSA to issue Claims Manual sections long before even proposed regulations are issued. This practice should be discouraged rather than encouraged. We can not stress enough the importance of the public comment process. Often, it is the only means available to claimants and their representatives to express their concerns. Finally, access to the POMS is limited to SSA offices, unlike the Code of Federal Regulations, rendering it more difficult for claimants and their representatives to remain up-to-date on its contents.

We recognize and share the Subcommittee's concern that there be uniformity at all levels of review. We believe that an alternative formulation of section 204 will adequately meet those concerns while eliminating the problems mentioned above. We therefore recommend that proposed section 204 be amended to require that the regulations of the Secretary, as published in the Federal Register, will govern determinations of whether individuals are disabled at all levels of review.

(c) Own-motion review (H.R. 3207)

There are a few concerns about the process of "own-motion review" which we would like to share with the Subcommittee and which we believe should be kept in mind in addressing the issue.

(1) NSCLC has recently begun to receive calls from advocates whose clients are being subjected to what we suspect is a new variation of "own-motion review" at SSA, one which most likely violates the claimant's right to due process. As we understand it, at least in the Atlanta region, if a local district office disagrees with an ALJ's favorable ruling for a claimant, it may file a request with the Chief ALJ in the region. If he/she agrees with the local office, he/she will suggest to the ALJ that he/she reconsider the ruling. If the ALJ refuses, the local district office may then appeal to the SSA regional office. During this period, the claimant is not paid the benefits to which he/she is entitled nor is the claimant or representative given notice that this internal appellate process is underway. We are very concerned about the constitutional implications of such a practice and request that the Subcommittee investigate it further.

(2) While it is true that many who disagree with a denial will appeal the ruling, many do not, for a wide variety of reasons, including confusion and the mistaken belief that SSA must be correct just because it is the government. If "own-motion review" is to continue, we believe that equity requires that SSA be required to review not only rulings favorable to claimants but also denials. Where an error is found in a denial, the case should be reopened.

(3) In *Holman* v. *Schweiker,* Civ. Action No. 78-494 (M.D. Pa.), the plaintiffs challenged SSA delays at various levels of review, including significant delays in the implementation of favorable decisions. In response to discovery requests on December 5, 1980, the Secretary provided a list of "conspicuous characteristics" which are utilized in determining which favorale ALJ opinions are reviewed before benefits are actually paid. The list raises serious questions regarding the standards which SSA is utilizing in reviewing favorable rulings. The list of thirty "conspicuous characteristics" currently in use includes "attorney representation". (Defendant's Answer to Plaintiff's Second Set of Interrogatories, Answer to Interrogatory No. 29, item No. 10.) In response to plaintiffs' question regarding the definition of a "conspicuous characteristic," SSA stated:

"Quality assessment data shows that claims with certain basic characteristics are generally error prone. Although the data neither establishes a 'cause and effect' relationship between the characteristic and the likelihood of error, nor that there is an error in every case having a characteristic, each of the characteristics does identify a universe of cases which are error prone. These characteristics are termed 'conspicuous characteristics.'" *Id.* No. 28.

Our experience has been that the evidence in a represented claimant's file has generally been developed after the representative became involved in the case, due to the representative's efforts to obtain the evidence. Further, where there is full file development evidencing disability, it is likely that earlier denials will be reversed. It is therefore ludicrous to penalize claimants by delaying implementation of favorable rulings solely because they wisely obtained representation. We request that the Subcommittee scrutinize this novel standard developed by SSA as well as the appropriateness of other "conspicuous characteristics" identified by SSA.

(d) The "Social Security Court" (H.R. 3865)

While we agree that there is a need to improve uniformity of decision-making in Social Security cases, we oppose the creation of a "Social Security Court." We believe that it would be more appropriate to scrutinize SSA's responses to judicial rulings to determine whether greater uniformity could be obtained. In particular, we believe that SSA's statutorily unauthorized practice of "non-acquiescing" in decisions with which it disagrees raises serious questions regarding whether SSA has acted in good faith over the years in promoting uniformity. A review of a few of SSA's actions in this area may be helpful.

In *Califano* v. *Yamasaki,* 442 U.S. 682, 699 (1979), the Secretary argued that class certification was not needed. "Restricted judicial review will not have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by] them within the jurisdiction of the courts rendering them." (The Supreme Court rejected the argument, finding class certification appropriate.) Despite this representation to the Supreme Court, SSA fairly routinely ignores ruling with which it disagrees, even in the judicial circuit where the decision was rendered.

In *Levings* v. *Califano,* 604 F.2d 591 (8th Cir. 1979), the Eighth Circuit Court of Appeals ruled that, under both the Social Security Act and then-HEW's own regulations, persons residing in certain types of nursing homes were entitled to receive

Supplemental Security Income (SSI) benefits. No class was ever sought or certified in that action. SSA not only did not "appeal [the] adverse decisions or abide [by] them within the jurisdiction of the court rendering them," it went one step further and issued Social Security Ruling No. 80-11c in which it "non-acquiesced" in the *Levings* ruling. The effect of SSA's decision not to acquiesce in the ruling is that it has refused to apply the decision to any other person, not even one in the same nursing home, much less someone residing elsewhere within the jurisdiction of the Eighth Circuit. Compare also the ruling of the Sixth Circuit Court of Appeals in *Boyland* v. *Califano*, CCH Unempl. Ins. Rptr. ¶16,912 (6th Cir. 1980), with SSR 81-1c. In *Boyland* the court rules that an illegitimately born child need not establish that the support received from the deceased wage earner was either"regular" or "substantial" in order to establish entitlement to receive children's survivor's benefits under Social Security. In SSR 81-1c, SSA once again refused to acquiesce in a court's ruling. [See the last paragraph, beginning with "SSA *holds* . . . ," emphasis included in the original.] And see, SSR 68-48c in which the Secretary said he did "not acquiesce in" the decision in RASMUSSEN v. GARDNER, 374 F.2d 589 (10th Cir. 1967), interpreting §211(a) of the Social Security Act and finding SSA's interpretation to be "too narrow." Courts continue to rely upon *Rasmussen* despite the Secretary's opposition. Here, the lack of uniformity is created by SSA's unwillingness to adhere to judicial rulings despite SSA's failure to appeal. See, for example, *Dickmann* v. *Finch*, 315 F.Supp. 1071 (E.D. Wisc. 1969).

Even where SSA has not issued a ruling refusing to follow a court's order, it has frequently done just that, ignoring others similarly situated until another court requires it to address the class aspects of the issue. For example, the district court's failure to certify a class in *Wiesenfeld* v. *Secretary of Health, Education and Welfare*, 367 F.Supp. 981, 986-987 (D. N.J. 1973) (three-judge court), which invalidated a gender-based classification in the Social Security Act, resulted in the need for additional litigation. First, the Secretary refused to provide relief to any one but the named plaintiff until the Supreme Court issued its decision affirming the three-judge court's ruling. 420 U.S. 636 (1975). Second, after that ruling, the Secretary applied the decision only prospectively to other individuals. At least two other suits were filed in order to obtain the benefits for the period prior to the Supreme Court's decision. See *Crumpler* v. *Califano*, 443 F.Supp. 342 (E.D. Va. 1978); *Hurvich* v. *Califano*, 457 F.Supp. 760 (N.D. Cal. 1978). A similar situation arose after the Supreme Court struck down another gender-based classification in the Social Security Act, see *Califano* v. *Goldfarb*, 430 U.S. 199 (1977). Shortly thereafter, the Supreme Court summarily affirmed three district court rulings holding unconstitutional the same provision. At that point, the Secretary took the position that he would only pay benefits to those few individuals injured by the provision who had received a final adverse decision from the Secretary and also instituted suit against the Secretary pursuant to 42 U.S.C. §405(g). *Wright* v. *Califano*, 603 F.2d 666, 668 (7th Cir. 1979). It was not until the Seventh Circuit's ruling in *Wright*, *supra*, that the Secretary finally agreed to pay all the benefits due to all individuals who had been injured by the provision held unconstitutional in *Goldfarb* who were members of the certified class in *Wright*.

Similar problems exist with disability cases. The cases addressing subjective pain which were discussed earlier reflect the problems created by SSA's unwillingness to adhere to judicial rulings, even where they are consistent among the circuits.

While we oppose creation of the court, the Social Security Court proposal itself raises a number of questions and considerations which we would like to address, each briefly. We strongly encourage the Subcommittee to hold additional, separate hearings on this very important issue.

1. *Quality of decisionmaking.* We are concerned both about the quality of decisionmaking and the independence of such a court. Given that the vast majority of cases coming before the court will concern disability claims, we are concerned that it will be difficult to attract judges of the same calibre as those on the federal bench and that the lack of variety will result in such routinization of case review that the court will eventually become nothing more than a "rubber stamp" for the Secretary; in effect, a new Appeals Council. As this Subcommittee is well aware, Social Security and SSI benefits are of critical importance to millions of Americans. The federal district courts have been, on the whole, sensitive and invaluable protectors of the rights of Social Security claimants. We believe that such sensitivity will be lost if a specialized court is created.

2. *Limitations on appeals from the Social Security Court.* The bill would limit appeals so that they may only be heard by the United States Court of Appeals for the District of Columbia and, then, review is restricted "to questions of statutory interpretation and constitutional issues." The gragraphical limitation will reduce the number of appeals taken on meritorious issues, as claimants will either no have

access to the District of Columbia Court of Appeals or will perceive that they do not. Wealthy claimants will be the best situated to file such appeals as they will be able to pay for the attorney's travel costs or the most likely to know how to secure counsel in the District. We suspect that the geographical limitation, much like the court itself, will recduce the public's (and the claimants') perception of the fairness of the system.

The limitation upon the issues which may be appealed effectively insulates the Court from review of the vast majority of its decisions. We do no think that this is a healthy result and find the parallels to the insularity of the Board of Veterans Appeals frightening. There, the absence of effective review (limited solely to constitutional issues) has resulted in incredible arbitrariness and the denial of eligibility to substantial numbers of individuals clearly eligible for benefits. We encourage the Subcommittee to eliminate this restriction on appeals and to also provide for appeals to all of the Circuit Courts of Appeal, based upon the residence of the appellant.

3. *Federal Rules of Civil Procedure.* It appears that the bill would remove the court from the coverage of the Federal Rules of Civil Procedure, providing that the proceedings of the court "shall be conducted in accordance with such rules of practice and procedure as the Court may prescribe." Given SSA's failure to implement judicial rulings to the benefit of all similarly situated to an individual plaintiff unless a class has been certified pursuant to Fed. R. Civ. P. 23 (see discussion of SSA's practice of "non-acquiescence"), it is critical that the ability to seek class relief be retained. Provision of class relief both reduces the number of cases which must be filed on identical issues and increases the uniformity of decisions made at the administrative levels. We therefore recommend that the court be bound by the Federal Rules of Civil Procedure.

(2) THE ATTORNEYS' FEES PROVISIONS

(a) The current system should be maintained

We believe that the attorneys' fee provision, set forth at 42 U.S.C. § 406, should be maintained. However, steps should be taken to rectify specific problems in the administration of the fees provision so as to encourage the private bar to represent Social Security claimants.

First, private attorneys representing claimants regularly complain that the delays in payment by SSA are so long that they are unable to rely upon the fees in projecting their offices' income. SSA should be required to expedite the payment of fees within an established, predictable time frame. Requiring expeditious payments would also benefit claimants. Before SSA pays a back award where a claimant was represented, it routinely withholds the full 25 percent, the maximum fee permitted under § 406. Often the fee awarded is less then 25 percent. Expeditious payment of fees to attorneys should result in SSA also paying claimants the remainder of their awards in a more timely fashion.

Second, while 20 C.F.R. § 404.975(b) and (c) provide to the contrary, private attorneys have indicated that SSA subtracts any workers' compensation offset before it determines the amount of the back award which is the basis for the attorney's fee. This results both in smaller fees and a great deal of unpredictability as to the possible amount of a fee award, discouraging the private bar from accepting the cases. A similar problem results from the requirement of Public Law 96-265 that SSI payments made to a Social Security claimant be subtracted from the Title II back award. Steps should be taken to assure that SSA complies with the requirement of 42 U.S.C. § 406(a)(A) that the fee will be taken from "the total amount of such past-due benefits."

(b) The current scheme is compatible with the Equal Access to Justice Act

A final issue regarding attorneys fees in Social Security cases is whether there is any conflict between the fee provision in the Social Security Act, 42 U.S.C. 406 and the recently enacted Equal Access to Justice Act, 5 U.S.C. 504, 28 U.S.C. 2412. Because the two statutes are carefully drawn to carry out very distinct policies, we believe that no problem is raised by their coexistence. Further, since the Equal Access to Justice Act only took effect on October 1, 1981 and we know of no decisions yet reached under it, it is premature at best to discuss its effect on Social Security litigation.

The fee provision in the Social Security Act does little more than provide an administrative mechanism for the implementation of the traditional contingent fee arrangement between attorneys and clients. This is particularly important to the attorney since Social Security payments are not reachable by legal process and a recipient typically has few other resources. It must be emphasized that all fees paid to attorneys under Section 406 come from a successful claimant's own money.

The Equal Access to Justice Act, on the other hand, represents a significant departure from established attorneys fee law. Based on the premise that Americans of limited means who come into legal conflict with the federal government are severely disadvantaged by the immense resources of the governments, it provides that the government itself must pay the fees incurred by parties who prevail over it. However, there is a major limitation on the right to collect fees. The government is only liable when it cannot persuade a court that its position in the litigation was "substantially justified."

Any analysis of the potential impact of the Equal Access to Justice Act, must therefore focus on the meaning of "substantially justified" and must recognize that the right to fees is a very limited one. It will be a heavy burden, indeed, for a litigant to persuade a judge that the government took an "unjustified" position in litigation. The federal courts pay a great deal of deference to the positions taken by federal parties. They will certainly recognize that there are two legitimately taken sides to nearly every dispute and the mere fact that one party prevails does not mean that the position of the other party was not "justified." Based on the legislative history of the Equal access to Justice Act, awards will likely be confined to a very limited class of cases where the federal government acted in bad faith, or where it chose to proceed despite the fact that previous rulings clearly demonstrated that its position was untenable. We believe that in these few cases it is appropriate for the government to bear the costs of litigation rather than to put the burden on the claimant through section 406. Any confusion which might arise between an attorney's claim under both the Equal Access to Justice Act and section 406 can easily be resolved by Social Security through its administrative responsibility under section 406. Double awards should obviously not be permitted and a determination of fees allowed from the claimant's lump sum benefit should await a decision on the Equal Access to Justice Act petition.

Because of the narrow nature of the right to fees under the new act, few attorneys will take cases where it would provide the only method of payment. Further, fees are not available in administrative hearings because they are not adversary in nature. As a result, the Act will certainly not encourage litigation which would not otherwise be brought. Finally, because fees cannot be paid out of the Social Security trust fund, the effect on the Social Security system will be minimal.

(3) ADMINISTRATIVE DELAYS

We believe that SSA has effectively delayed resolution of the delay issue which has haunted it and injured claimants for years and has been the subject of numerous lawsuits as well as many hearings before this Subcommittee. For awhile, at least in jurisdictions where court orders existed requiring specified time frames, it appeared that SSA was complying well in minimizing the delays at the ALJ stage. However, since it issued proposed regulations with a 120-day time frame as required in the *Blankenship* litigation, it has retreated from that standard, seeking a 165-day time frame with no enforcement mechanisms. This period is not so far from the delays which plaintiffs in the delay cases orginally sought to eliminate.

SSA has similarly been very generous with the state units, refusing to impose specific time frames for completion of work on a case at the initial and reconsideration levels. And, when a claimant seeks judicial review of an unfavorable ruling, he/she is faced with further delay as SSA, via the U.S. Attorney, seeks one continuance after another in filing the defendant's answer. Unfortunately, the U.S. Attorney's motions for delay have become so routine that judges regularly grant them without question, in some cases even before they are sought.

The result is that, while the quality of decisionmaking has remained low, delay remains rampant at all levels of the administrative process, including federal district court. Hopefully, the recent action taken in the *Blankenship* case, requiring SSA to commence payment of benefits, subject to a right of recoupment, where the SSA delay exceeds specified limits, will motivate SSA to expedite decisions more rapidly.

We encourage the Subcommittee to continue to monitor the problem and to seriously consider the statutory imposition of time frames at all levels of the administrative process.

Thank you for the opportunity to appear and testify this morning.

Mr. JACOBS. We are pressed for time, so there will be no questions. Your testimony itself is clear, and the points you have emphasized are a part of the record. Thank you for your testimony.

Our final witness is Mr. Bruce Ransom, Jr., president of the AFGE Council, Office of Hearings and Appeals Locals.

STATEMENT OF JOHN HARRIS ON BEHALF OF BRUCE C. RANSOM, JR., PRESIDENT AFGE COUNCIL, OFFICE OF HEARINGS AND APPEALS LOCALS

Mr. **Harris**. Mr. Ransom was not able to be present today.

My name is John Harris, and I am president of the AFGE Council of Social Security Field Office Locals, the District Offices. I am afraid I don't understand the time constraints.

Mr. **Jacobs**. Generally, it is 5 minutes for testimony.

Mr. **Harris**. Mr. Ransom had submitted a statement for the record, which I will ask to enter. I will briefly say what I can about the problems that I understand you are addressing.

First of all, the problem we have is historical in nature. This is not new. It is recurrent. I find it disturbing that the Congress finds itself trying to pass legislation to manage the administration. I think it is dangerous. I think that what you must do is hold your administration accountable for its actions, and make them manage more effectively.

The 1978 amendments of disability whereby your required reviews of disability decisions was unnecessary. The administration could have and should have done those things, had been doing those things, and stopped only because of mistakes they had made, staffing constraints, and lack of resources. The pattern that we have seen in recent years of disability determinations in State agencies increasing in allowances, and then decreasing in allowances, of conversely the administrative law judge increasing affirmations almost in a battle, really is a result of all the management problems that were created in the social security system by black lung and SSI, which I think you already know.

We now find ourselves in a new wave of initiatives from Congress and management. They are going to create more problems as I see it. Your efforts in 1978 to improve the disability process by having periodic reviews, by having the preeffectuation reviews, are now even being undermined by administrative efforts to allegedly tighten up on disability administration.

The administration has proposed to speed up CDI's, as a result of that they are now having to propose to cut back on the preeffectuation review process. They are increasing the time it is taking for the processing of initial claims because they are overlaoding the system.

The process of CDI's is increasing the number of appeals. It has resulted in hasty determinations by State agencies which are understaffed and incapable of handling this new workload.

The administration is now faced with choices such as having to contract out the CDI function. They are considering among themselves possibilities of having the determinations on CDI's being made by insurance companies, or other third-party groups.

I listened to Mr. Pickle acknowledging and expressing admiration for the expression of one of the previous witnesses who said he had some solutions. I don't have any. I can give you some basic ideas.

Clearly you are understaffed, but I want to emphasize again, if it is difficult to legislate morals, it may be even more difficult to legislate effective management. I don't think that you can solve the problems as you are sitting here by instructing decisionmakers on how to make their decisions, if you have bad decisionmakers.

In closing, I want to make one final observation. I was listening to the testimony, and it occurred to me, in this battle between who is doing it right, the State agencies or the ALJ's. The truth lies in the middle.

I believe that the determination of disability is not an exact science. There is a grey area, an area of judgement involving sometimes issues of pain, yes, involing residual functional capacity, age, vocation. I believe that the guidelines given to the State agencies are much too stringent, and they need more latitude, but conversely that the administrative law judges need more guidance.

I think that that balance, which I believe you can apply by sensible management techniques, will solve your problem rather than having to enact legislation to tie up your hands and not make you able to deal with serious problems.

That is all of my comments. Do you have any questions?

[The prepared statement follows:]

STATEMENT OF BRUCE C. RANSOM, JR., PRESIDENT, AFGE COUNCIL 215 AND AFGE LOCAL 3615

Mr. Chairman and Committee Members, I am Bruce Ransom, President of A.F.G.E. Local 3615 and President of the Council of Locals at the Social Security Administration's Office of Hearings and Appeals.

In January 1979 the staff of the House Social Security Subcommittee released a "Survey and Issue Paper" on the management of O.H.A. That report concluded that ". . . the greater emphasis in all phases of the [hearings and appeals] has been placed on 'moving the cases' rather than rendering fair and sound decisions."

In March 1979 this Subcommittee held hearings on this matter and heard testimony of over-management, mismanagement, empire-building and cronyism in the Office of Hearings and Appeals.

Subsequently, the Director of O.H.A. and his deputy were removed and replaced by an interim Director while a search was conducted for a permanent replacement. A permanent Director served at O.H.A. from the fall of 1979 until the spring of this year. Mr. Hayes who appeared before this Subcommittee last Friday recently joined O.H.A.

Mr. Chairman, I regret to inform you that while some cosmetic changes have been made in the way O.H.A. does business, no substantive changes have been made.

The reason for this situation should be obvious. The same top management officials who were put in place by former Bureau Director Trachtenberg appeared before you last week with Associate Commissioner Hayes.

It is this management layer which is responsible for the continuation of the untenable management practices at the Office of Hearings and Appeals.

Associate Commissioner Hayes testified Friday that while the O.H.A. "management" and "administrative" staff has been significantly increased over the last several years, he has no plans to further increase it. The problem, of course, is that neither he nor his predecessors has made any attempt to roll back those questionable increases.

The same could be said for virtually all of the management practices that were discredited before this Subcommittee in March 1979.

While the Directors of O.H.A. have come and gone, the posture of management has remained the same.

For example, while a great deal of emphasis continues to be placed on "moving the cases", only lip service is given to whether the claims are decided correctly.

Although the Bellmon Amendment appeared to mandate simply a return to "own motion" review by the Appeals Council, its implementation included the establishment of a new little bureaucracy in SSA headquarters in Baltimore.

The O.H.A. so-called "Quality Appraisal" staff which is regarded as nothing more than a joke by the bureau's professionals, continues to compile statistics and issue meaningless reports. This expensive and unnecessary unit could significantly contribute to O.H.A.'s mission if its members were reassigned to adjudicate Social Security claims.

The goal of O.H.A. management, its ALJs, its doctors, its Union, and others should be the same. However, management continues to take a "them against us" attitude.

The blame for this rest squarely with the middle and top career managers who continue to operate in the tradition of Robert Trachtenberg.

My remarks have been limited to the management problem at the Office of Hearings and Appeals, especially in Central Office. Problems that exist in Central Office are copied by the managers in the field. This situation has resulted in numerous unfair labor practice charges throughout the Office of Hearings and Appeals.

Mr. Chairman, this concludes my remarks. I would be pleased to answer any questions you or other members of the Subcommittee may have. I would also be pleased to submit documentation regarding my prepared statement.

Mr. **Jacobs**. I don't have any questions. I thank you for your testimony.

Mr. Ransom's statement, is that the statement you delivered?

Mr. **Harris**. No. I expounded on some other matters, as I was listening, and which I thought needed to be said about the problem.

Mr. **Jacobs**. Let me ask one question. One of the previous witnesses alluded to own-motion review as applying generally to situations where the decisions were against the Government rather than situations that affirmed the Government's position at the lower levels. Is that the way it is, do you find that to be the case?

Mr. **Harris**. I can't answer that. Mr. Ransom will have to answer that. I don't deal with that specific area myself. I will certainly ask him to tell you that.

Mr. **Jacobs**. Would some witness who appeared earlier today care to make some comments?

Judge **Brown**. The own motion review is a word of art in OHA, which relates primarily, if not exclusively, to the review of favorable hearing decisions. That is how the term is pretty much being used in practice right now in relationship to the reviews that were mandated by the Bellmon amendment to the disability amendments of last year.

Mr. **Jacobs**. Staff has mentioned the 5-year factor also; is that correct, or where there has been no review for some period of time.

Judge **Brown**. We are not talking about a mandate of review for nonpermanent disability every 3 years, and that is what is described in some of the testimony as the accelerated CDI's, or continuing disability investigations.

Mr. **Jacobs**. Maybe we ought to look at that. Perhaps there can be a review of situations where things are going entirely from the Government. There might be something wrong, or worth looking into there.

Judge **Brown**. The position of the judges is that our life is an open book. You can review every decision.

Mr. **Jacobs**. I assume you mean your official life.

Judge **Brown**. With the kinds of statements about conflicts of interests, or statements about our financial situation, I think other areas also become public knowledge.

Mr. **Jacobs**. We thank the witnesses for the record, which will be very helpful.

The hearing is concluded.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

NORMAN Y. MINETA
MEMBER OF CONGRESS
13TH DISTRICT, CALIFORNIA

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PUBLIC WORKS AND TRANSPORTATION
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September 17, 1981

Hon. J.J. Pickle, Chairman
Subcommittee on Social Security
House Ways and Means Committee
A522 House Annex 1
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed is a copy of a letter I recently received from a former Social Security Claims Representative who currently counsels and represents Social Security claimants. Mr. Trozan objects that 20 USCA section 406(a) does not give equal treatment and protection to non-attorneys representing Social Security claimants.

Mr. Trozan and I would both appreciate your comments on this matter and I would be particularly interested in knowing whether your Subcommittee anticipates any changes in the law concerning representation of Social Security claimants as part of a more comprehensive legislation affecting the Social Security program.

I look forward to hearing from you and appreciate your consideration.

Sincerely yours,

NORMAN Y. MINETA
Member of Congress

NYM/sjd/w
enclosure

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

SOCIAL SECURITY COUNSELING SERVICES
"We Cut The Red Tape"

July 3, 1981

The Honorable Norman Mineta
House of Representatives
Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Mineta:

I would like to bring to your attention a provision of the Social Security laws that I believe to be highly unfair, discriminatory and unconstitutional. This provision is found in 20 U.S.C.A., section 406(a) and deals with rules for representation of Social Security claimants before the Social Security Administration. This provision of the law authorizes both attorneys as well as non-attorneys to represent persons at all stages of the Social Security Administrative appeals process.

So far the rule is fair enough, but then it goes on to state that where the claimant is represented by an attorney, the Social Security Administration will (1) approve a fee that the attorney may charge, and (2) will withhold up to 25% of the claimant's back benefits to pay the attorney's fees. My objection to this law is that it fails to give equal treatment and protection to non-attorneys. This law recognizes that there may be cases where a non-attorney is perfectly competent to represent and give valuable services and advice to a claimant. Why then should the non-attorney not be reimbursed and protected in the same way that an attorney is?

I am a former Social Security Claims Representative and for the past three and a half years have counseled and represented Social Security claimants. Fortunately, the Regulations (20 CFR 404.977) are a bit more liberal than the statute and permit me to charge and collect a fee, if it has been approved by Social Security. However, even under the Regulations, I, as a non-attorney, am discriminated against because Social Security will not withhold a portion of the claimant's check to pay my fee. This can lead to unnecessary problems whenever an irresponsible or unscrupulous claimant spends his backpay award or simply refuses to pay the authorized fee.

These days claimants are in need of more, not less representation as they deal with the Social Security Administration. Attorneys have been largely unwilling or unable to fill this need. Legal services for the needy have proven to be only a partial answer. In the

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meantime, I, in my limited capacity, have been able to provide a valuable service for many claimants. However, I am experiencing unnecessary problems with clients as well as with Social Security because of this discriminatory provision. I would ask you, therefore, to assist me by introducing an amendment which will put non-attorneys on an even footing with attorneys as far as representation in Administrative proceedings is concerned. This statute already provides that before non-attorneys can represent a claimant that they "shall show [to the Social Security Administration] that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render ... valuable service." This ensures that unqualified non-attorneys shall not be able to foist themselves upon unsuspecting claimants.

Thank you in advance for your consideration of this matter. I shall be happy to meet with you to discuss this matter in greater detail, if you so desire. Looking forward to hearing from you.

Sincerely yours,

Peter A. Trozan

Congress of the United States
House of Representatives
Washington, D.C. 20515

August 24, 1981

Dear Jake:

I have been contacted recently by an attorney in my district who has raised a number of intelligent points about proposed changes in the disability provisions of the Social Security Act. I would greatly appreciate it if you could furnish me with a clarification of some of the points raised, all of which are prompted by reforms included in HR 3207.

The first point has to do with the requirement that 35% of all awards and reversals of cessations by Administrative Law Judges be reviewed by the Secretary. I realize that the review requirement is already part of the law. Instituting a further requirement that 35% of awards and reversals be automatically reviewed is commendable, but shouldn't that requirement also pertain to denials or cessations decisions? Although the claimant has the right to appeal a denial made by the ALJ, it is too often the case that such an appeal results in lengthy court action. Court action is costly and very time consuming. It would seem to be entirely sensible and equitable that Own Motion Review be directed at denials, therefore, as well as awards decisions. At the least, we would be sparing the government judicial costs. At the most, we would be applying the review requirement in a manner which would protect disabled claimants' rights to disability benefits.

Another point I would like to raise is in regard to the proposed uniform standard of pain provisions in HR 3207. Again, I understand that the issue here is uniformity and streamlining and that a great many dollars will be saved by adhering to a uniform definition of pain. However, the attorney I mentioned above has diagrammed several cases he has handled in which the disabled claimant is suffering from extreme pain that is not immediately diagnosed or pinpointed. Such cases involving hard-to-diagnose illnesses--arthritis, for instance--often cannot be precisely defined in the manner which a uniform standard might require. Pain and illness are subjective matters. Should there not be allowances for those maladies that do not fall under the uniform standard, but are nontheless debilitating for the claimant?

Finally, the issue of extending to 24 months the requirement of a illness' duration for disability benefits has prompted this point. The attorney's experience with disability cases and ALJ's is that the concept of "expected to last" is rarely taken into account when cases are decided. Do ALJ's routinely deny benefits, as the attorney has alleged, because an impairment has not lasted 12 months, without regard to the concept of "expected to last" 12 months? Requiring that an ailment must have been in evidence for 24 months, or be expected to last 24 months, may only exacerbate the basic problem that the "expected" concept is often not adhered to in individual cases.

As I said, I think these points are significant and may well have been addressed already by your subcommittee. If so, please let me know how you have responded to these matters; if not, I would be interested in your review and comments on the points raised.

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

Thank you for your attention to this particular matter, and your general concern for the Social Security system's current problems.

Sincerely,

Toby Moffett
Member of Congress

The Honorable J.J. Pickle
Chairman, Subcommittee on Social Security
A522 HOB, Annex 1
Washington, D.C. 20515

TM/ar

THOMAS A. BOTHWELL
ATTORNEY AT LAW
~~538 1/2 SIXTH STREET~~ 829 7th Street
CLARKSTON, WASHINGTON 99403
(509) 758-1618
Home: (509) 758-3065

November 6, 1981

Social Security Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, DC 20515

Re: Social Security Appeals

Dear Honorable Representatives,

I understand your subcommittee has recently conducted hearings on a variety of issues concerning the Social Security appeals process.

On behalf of the many deserving claimants whom I have represented and will continue to represent, who are victims to delay in hearings of up to a year and frequently more, I urge you to pressure the administration to hire additional administrative law judges and to institute improvements in the process to alleviate these outrageous delays.

Thank you for your consideration.

Respectfully,

Thomas Bothwell

TB:ms

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-0771

October 27, 1981

COMMITTEE ON
OCT 30 1981
WAYS AND MEANS

John J. Salmon, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Salmon:

As the Administrator of the California State Agency responsible for the adjudication of SSA/SSI disability claims, I wish to file a written statement for the printed record of the hearing on the Social Security appeals and case review process. My comments and proposals will be confined to issues involving Administrative Law Judges (ALJ) and attorney representatives.

First and foremost is my deep concern with the lack of uniformity in the adjudicative principles employed by ALJs. This is reflected by the fact that, over the years, national Disability Determination Service (DDS) decisional accuracy as determined by SSA has consistently approximated 99.5%. Yet ALJs are reversing approximately 60% of all reconsideration affirmations coming before them on appeal. Indeed, 21% of all disability benefit recipients have been placed on the rolls as a result of ALJ decisions. If ALJ's were required to utilize the same adjudicative criteria as the state DDS's, I firmly believe that significant cost savings would be realized. It is imperative, therefore, that uniform standards be applied at all levels of adjudication.

I strongly support those proposed amendments to the Social Security Act, as described in H.R. 3207, which would:

1. Mandate that the Social Security Regulations, the Social Security Rulings, and the adjudicative standards of Part 4 of the Program Operations Manual System (POMS) shall govern disability determinations (Sec 204).

2. Eliminate the assessment of pain and other symptoms unless supported by objective clinical findings (Sec 205(a)).

3. Establish a mechanism by which ALJ decisions can be reviewed (Sec 203).

Such actions will ensure uniformity of decision making and remove the potential for subjective decisions on the part of ALJs.

A second area of concern involves attorney representatives who fail to cooperate with the DDS at the reconsideration level. Their apparent intent is to force the DDS into affirming the initial decision as written, thereby expediting elevation of the claim to the hearing level. The apparent incentive for this action is the improved probability of a substantial fee for the attorney when the case goes to a hearing. Such circumvention of the reconsideration process wastes SSA District Office and DDS time and creates additional work for OHA. Therefore, I propose that any claim at the reconsideration level, where evidence of failure to cooperate by the claimant or representative exists, be excluded from higher levels of appeal.

I further propose that former ALJs be prohibited from representing SSA claimants for a period of 3 years following termination of employment with OHA. We are experiencing situations in California in which ALJs leave office, set up in private practice, and immediately begin representing Social Security disability claimants. This activity raises questions as to conflicts of interest.

Finally, I recommend that disability claimants take on the responsibility of paying attorney fees. Currently, SSA deducts such fees from benefits and makes the payment directly to the attorney. Since it is the claimant who is receiving the benefit of an attorney's services, it should be the claimant who pays the fee. Claimants would simply pay the fee out of their retroactive benefits.

Thank you for the opportunity to provide input on these vital issues.
If you have any questions or desire further information, please contact me.

Sincerely,

Gary G. Adams

GARY. G. ADAMS
Deputy Director
Disability Evaluation Division

Office of Hearings & Appeals
Room 7B41, 1100 Commerce St.
Dallas, Texas 75242

November 6, 1981

Mr. John J. Salmon
Ways & Means Committee
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Salmon:

It is requested that you include the attached report in the record on the hearings before the Social Security Subcommittee on October 23rd and 28th, to become a part of the record.

We are submitting these statements as a group of concerned taxpayers and out of concern for the Trust Fund.

We appreciate the opportunity to have our statements admitted into the record for consideration of the full Subcommittee.

Sincerely yours,

Edna M. Poappylitty (11yrs.)
[illegible] (10 yrs.)
[illegible] D. Woodward
Mabel Philips (30 yrs)
Berta Lewis (12 yrs)
Mary L. Warren
M. Swca Batcher (3)(SSA/OHA)

Ella Mae Provazek (O.H.A. 1[illegible] yrs) 20 [illegible] Federal
Frances Miller (8yrs)
Edna Seahalt
S. Brown (11 yrs)(4 yrs SSA)
Terre (Crump) Bistany (13 yrs)(29-fed)
Rachel Banks, HC
(17yrs Fed., 4yrs OHA)

[illegible] (15 1/2 yrs. Fed. Service)

EMPLOYEES OF DALLAS, TEXAS
(Downtown) OFFICE

Attachment - Report on
Problems in OHA

November 6, 1981

Honorable J. J. Pickle, Chairman
Social Security Subcommittee
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

MR. CHAIRMAN:

GREETINGS FROM TEXAS!

We are a group of employees who work for the Social Security Administration, Office of Hearings and Appeals in the Dallas Downtown Office, Texas. We are the support staff for Administrative Law Judges who hear Social Security cases on appeal and issue decisions. Most of the undersigned have been performing the duties required of staff in the field offices for approximately 8 to 13 years.

The service territory that we cover includes most of Central Texas and at times the Houston, Austin and Baton Rouge vicinity, as well as many out-of-region dockets.

There are many problems in the Office of Hearings and Appeals, and we plead with you to listen to our story.

To begin with, some of us previously worked in the Office of Hearings and Appeals Regional Offices when there were only five employees. Now there are many employees in the Regional and Central Office management areas. When there were only five employees, there was greater service to the field offices and the ALJ's and due process were treated with respect.

The first crisis was the Black Lung program. We tackled that, taking many long, hard out-of-region dockets in the coal mining towns to rescue them from extremely heavy backlogs. All of this in addition to maintaining the workload in our home regions was accomplished in a well coordinated commendable manner. We studied the new laws, forms and procedures on our own initiative under the tutelage of the ALJs.

Before we had caught our breath from that additional workload, the SSI law was passed. We also tackled that. Even though our salaries and overhead are taken from the Trust Fund, approximately half of our time is spent on welfare cases (SSI).

In the beginning of the Supplemental Security Income program, the ALJ's in Dallas Region were called to Houston, Texas by the Bureau Director and asked to vote on what they needed to handle the increased workload, i.e., Black Lung, SSI, and new Title II disability cases which had increased. A formal report will show that they unanimously said:give us workers and give us supplies. The agency was given money for staff and supplies, but it was diverted to the management/administrative areas in the Regional and Central Offices and was the beginning of the "Innovative anagement Era of 1976", which by our definitions means castlebuilding and manipulation of the ALJs. We have been eyewitnesses to it all.

We are advised that you have been told that by combining:

1. Strong Innovative Management Programs
2. 100 additional ALJs
3. Updated equipment

Equals: 45 decision per ALJ per month

This sounds great! But who is to benefit, the claimants, due process and the Trust Fund, or could it be the "Innovative

In Texas, we had "pooling", "configuration", and "reconfiguration", (which is actually one and the same), all at once in our office. Here is what happened. The innovative OHA managers of 1976 vintage hand selected a super innovative manager to be ALJIC (Administrative Law Judge In Charge) of the Dallas Office, after the closing date of the vacancy announcement for the position, and over other qualified, timely applicants in Texas who were high producers. This ALJIC arrived in Texas the beginning of June 1980, at the expense of the Trust Fund, and was placed over four consciencious top producing ALJs in the office. In no time at all, the ALJIC began manipulating the other ALJs staff and cases. By December 18 , 1981, the ALJIC seized the ALJs staff and placed us all in a "pool" under the direct supervision of the HOA. The HOA was hired as an innovative Administrative Officer with no prior OHA experience or SSA experience and little, if any, legal education or training. On December 17, 1980, all ALJs were ordered to return all cases not heard back to the master docket and advised that there would not be any hearings scheduled for two to three months. (Memo attached, Exhibit B) Needless to say, claimants were crying to their representatives and their Congressmen. Our hands were tied! Files were shipped out to other offices. We know some were shipped to Ft. Worth, Houston, Oklahoma City, the OHA and SSA Regional Offices and the attached monthly report will confirm that when the ALJIC issued 87 decisions in one given month, that over 30 of these were typed for him in Houston and some other place. (Exhibit C) The other four Administrative Law Judges were told by the HOA that they were to look in a drawer with their name on it and the cases in there were the ones that they could dictate decisions on. But lo, when they got there, the cupboard was bare, and so, our poor Judges had none! It should be duly noted that the ALJIC only issued a large number of decisions on this one time basis, when in fact, one month the ALJIC issued approximately 5 decisions, so in reality you should divide the 87 by 2.

The attached graph prepared on one of the ALJs in the office will give you a bird's eye view of what happened and would be typical of the other ALJs in the office. Keep in mind that during this time the ALJIC had pirated all the ALJ's staff for himself. He was also allowed unlimited use of employee overtime for this office as well as for employees outside the office. It should be duly noted that this outside expense has not been counted against the overhead of the "Pilot Program" in Dallas. There appears to be a camouflage of the enormous cost of this disaster.

Employees asked the HOA to give us a list of the files shipped out of the office in order to be able to respond to telephone inquiries from Congressmen, representatives and the claimants but were told we were not allowed to have the information. Needless to say, many costly hours were spent looking for files that were not even in the office. The only way we knew that the files were shipped out was word of mouth from co-workers in the other offices and the attached report. We could provide statements or testimony from these employees for verification.

Managers". Let's be realistic about all this. Even though 5 U. S. C., 5106 states, in part, ". . . (c) Appropriated funds may not be used to pay an employee who places a supervisory position in a class and grade solely on the basis of the size of the organization unit or the number of subordinates supervised. . . ." (Exhibit A, attached), the basis for promoting the Administrative Officers (A/Os), Hearing Office Administrators (HOAs), and the Regional Management Officers (RMOs) is the number of people they are allowed to supervise, i.e., the ALJ's staff and/or slots in the regional and central offices. These slots should be in productive positions in the field offices and the Appeals Council. These layers of management are a detriment to due process. Since 1976, OHA and SSA have been working in consortium to come up with innovative schemes to manipulate the ALJs and/or their decisions. They have never been successful in dividing the ALJs and support staff, however. We have remained loyal to the mission of the Bureau throughout it all.

Mr. Chairman, one reason that we feel such a burden in the Dallas Downtown Office is that we have been victims of these costly innovative management programs and feel that you and the Committee should be fully advised of what actually takes place in a field office during "innovative management initiatives", "pooling", "reconfiguration", "configuration" or the other costly programs the trust fund has sponsored.

Many of our employees left because of the abusive treatment by the ALJIC and his HOA, however, since the cessation of the program, we have been able to bring some of them back.

We have seen the report prepared by our innovative managers entitled "Close-out Report Hearing Office Reconfiguration". The report on the Texas disaster is noticeably absent. After making inquiry, we hear that it has been said of us that we sabotaged it. We give you our Texas Word of Honor that we did not sabotage the program, that we had no control whatsoever over it and take umbrage with this accusation. Neither did the four consciencious, top-producing ALJs sabotage the program. Neither did they have any control over it. The fault lies with the program itself and its inovative managers. Let's face it!
It was not us who lost files, shipping them all over the country.
It was not us who cancelled all the hearings.
It was not us who took the ALJs staff away.
It was not us who lost District Court Remands.
It was not us who hired 3 people from the outside to sneak in on the week-ends, force the locks off the ALJ's file cabinets, seize all their ALJ files (which included their personal notes and their decisions), place these all in one room mingled together, changing the filing system from alphabetically to numerically by social security number without advising anyone.

It should also be noted that an innovative management investigative team spent several hours in the office investigating these problems and we certify that we advised them of the problems as stated herein and we note that these problems are not mentioned in the report on reconfiguration. Why not?

On November 5, 1981, it was announced by OHA managers that this pooling will be implemented coast to coast, no matter what.

The fundamental problem is that the mistakes made from 1976 to 1979 have never been addressed and have never been corrected. It is our opinion that someone should listen to approximately 700 Administrative Law Judges with Juris Doctorates. Could they all be wrong?

SINCE THE REMOVAL OF THE ALJIC AND HOA, CONDITIONS ARE NOW BACK TO NORMAL. THE DALLAS D/T OFFICE OFFICE HAS ROTATING ALJICS AND NO HOA. PRODUCTION HAS INCREASED. MORALE HAS GREATLY IMPROVED. THERE IS A BETTER SERVICE TO THE PUBLIC IN PERFORMING THE MISSION OF THE OHA. (THE ONLY PROBLEM THAT WE HAVE IS THAT THE INNOVATIVE MANAGERS TOOK AWAY ONE OF OUR MAG CARD TYPEWRITERS AND WILL NOT REPLACE ANY PERSONNEL IF THEY RETIRE OR LEAVE. WE ARE BEING PUNISHED IN THIS MANNER.)

Sammy [illegible] Hill
H/A
[illegible] L. Rebel, Hrg Analyst
Mabel L. Phelps, Hrg Analyst
Brenda Harris, Hrg. Clerk
[illegible] Hrg. Clerk
Vicki Hightower, Hrg. Clerk
N. Jean Starkweather, H. asst.
Ella Mae Provazek, Hrg. asst.
S. Brown, Hrg Asst.

Mary L. Warren
Edna M. Poappelitty, Hrg Clerk
Frances Miller, Hrg Clerk
Edna Seabolt, Docket Clerk
Teresa Bistony, Hearing Assistant
Rochelle Banks, HC
(19 yrs Fed., 4 yrs OHA)

LIST OF EXHIBITS

EXHIBIT A	Copy of Section 5106, 5 U.S.C.
EXHIBIT B	Seizure of ALJ's Cases, Memo, 12/17/80
EXHIBIT C	Copy of Monthly Report for January 1980
EXHIBIT D	HOLLAND'S GRAPH during Reconfiguration Era
EXHIBIT E	Seizure of ALJ's staff, Memos 12/18/80 & 12/30/80 (2 pages)
EXHIBIT F	Unlimited Overtime Memo, 11/25/80
EXHIBIT G	Hearing Office Survey Memo, 3/17/81
EXHIBIT H	Office Configuration Memo, 1/20/81
EXHIBIT I	Request for Typing Assistance Memo, 12/30/80
EXHIBIT J	Dead Time, 1/21/81

However, this requirement does not prevent the use of organizational or other titles for internal administration, public convenience, law enforcement, or similar purposes. (Pub. L. 89-554, Sept. 6, 1966, 80 Stat. 452; amended Pub. L. 95-454, Oct. 13, 1978, 92 Stat. 1224.)

§ 5106. Basis for classifying positions

(a) Each position shall be placed in its appropriate class. The basis for determining the appropriate class is the duties and responsibilities of the position and the qualifications required by the duties and responsibilities.

(b) Each class shall be placed in its appropriate grade. The basis for determining the appropriate grade is the level of difficulty, responsibility, and qualification requirements of the work of the class.

(c) Appropriated funds may not be used to pay an employee who places a supervisory position in a class and grade solely on the basis of the size of the organization unit or the number of subordinates supervised. These factors may be given effect only to the extent warranted by the work load of the organization unit and then only in combination with other factors, such as the kind, difficulty, and complexity of work supervised, the degree and scope of responsibility delegated to the supervisor, and the kind, degree, and character of the supervision exercised. (Pub. L. 89-554, Sept. 6, 1966, 80 Stat. 453.)

71/82

§ 5107. Classification of positions

Except as otherwise provided by this chapter, each agency shall place each position under its jurisdiction in its appropriate class and grade in conformance with standards published by the Office of Personnel Management or, if no published standards apply directly, consistently with published standards. When facts warrant, an agency may change a position which it has placed in a class or grade under this section from that class or grade to another class or grade. Subject to subchapter VI of chapter 53 of this title, these actions of an agency are the basis for pay and personnel transactions until changed by certificate of the Office. (Pub. L. 89-554, Sept. 6, 1966, 80 Stat. 4535; amended Pub. L. 95-454, Oct. 13, 1978, 92 Stat. 1222 and 1224.)

§ 5108. Classification of positions at GS-16, 17, and 18

(a) The Director of the Office of Personnel Management may establish, and from time to time revise, the maximum numbers of positions (not to exceed an aggregate of 10,777) which may at any one time be placed in—

(i) GS-16, 17, and 18; and

(ii) the Senior Executive Service, in accordance with section 3133 of this title.

A position may be placed in GS-16, 17, or 18, only by action of the Director of the Office of Personnel Management. The authority of the Director under this subsection shall be carried out by the President in the case of positions proposed to be placed in GS-16, 17, and 18 in the Federal Bureau of Investigation.

(b)(1) The number of positions of senior specialists in the Legislative Reference Service, Library of Congress, placed in GS-16, 17, and 18 under the proviso in section 166(b)(1) of title 2 are in addition to the number of positions authorized by subsection (a) of this section.

EXHIBIT A

Stan: 12-17-80

All ALJ's

Attached is a photocopy of your caseload as of 12-15-80.

Please take the following actions if your staff has not already done so:

A- Transfer all Item ① cases to the Master Docket (Exception: Judge Martin keep 1 no-show case & handle as required)

B- Keep all Items ②, ③ & ④ cases, hearing them as indicated, developing, or ready for decision. We will move those later as required as the system gears up

C- Transfer all Item ⑤ & ⑥ cases to "Hearing Clerk Unit". Have your staff take them into room 7E7H (Judge Mans old office) & contact Shirley Doolan to show which cases are ⑤'s & which cases are ⑥'s

Also please advise by Memo how many file cabinet drawers you anticipate needing for your personal files (exclusive of cases).

R E Dockery Jr., ALJIC

EXHIBIT 8

IEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

' : Judge R. E. Dockery, Jr.
ALJIC

DATE: January 2, 1980

REFER TO:

.OM : Master Docket

JBJECT: Consolidated Monthly Workload Report -

	HEARINGS HELD	DISPOSITIONS	TOTAL PENDING	PENDING NOT HEARD	PENDING SCHEDULED	AGED
MASTER DOCKET			475			
BRANDES		23				
DOCKERY		87				
HOLLAND	25	18	39	4	0	15
HARRIS						
MARTIN		8				
STARK		8				
TOTALS	25	[illegible]	516	4	0	15

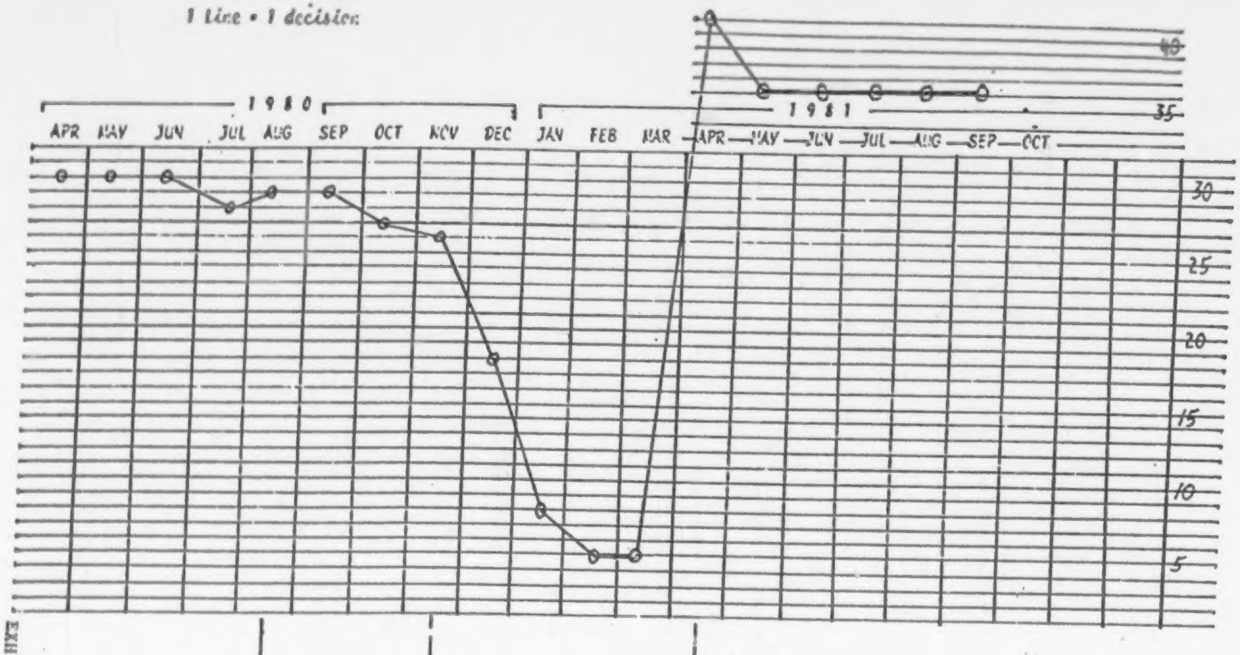
SERVICE AREA RECEIPTS:

Received Dec. from Houston---29 *
Outside areas-- 3
32

EXHIBIT C

PRODUCTION OF ALJ HARRY T. HOLLAND
UNIT

1 Line • 1 decision



1½ H/A & 1 H/C

H/A Bistany transferred from ALJ Holland's Unit to ALJIC Tockery's Unit

ALJIC Tockery recalled all cases from ALJs & cancelled all hrgs from NOV '80 to FEB '81

"Pool" disbanded & all H/As & H/Cs returned to former Units 2 fulltime H/As & 1 H/C

EXHIBIT D

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TO : All Personnel

DATE: December 18, 1980

REFER TO:

FROM : Hearing Office Administrator, Downtown Dallas Hearing Office

SUBJECT: Realignment of Personnel

Effective immediately, Hearing Clerks are reassigned to the direct supervision of the Hearing Office Administrator as follows:

Brenda Harris - Detached from ALJ Stark Unit and reassigned to the Hearing Clerk unit;

Edna Poafpybitty - Detached from ALJ Holland Unit and reassigned to the Hearing Clerk unit;

Melva Butcher - Detached from ALJ Brandes Unit and reassigned to the Hearing Clerk unit;

Today and until further notice, these personnel will temporarily occupy the desks in the open area immediately outside the offices of Judges Dockery and Brandes. Unless otherwise directed by the HOA, the initial priority assignments of this work unit will be the typing of decisions already dictated, draft and final, the mailing out of decisions that are typed and signed and the bringing of fee petitions current. All assignments of work will be made by the HOA and a recordkeeping system has been established for these assignments.

The appointment of a Hearing Clerk Group Leader is not made at this time.

Hearing Assistants are expected to answer telephone and mail inquiries on cases assigned to specific ALJs. Telephone and mail inquiries regarding cases not assigned to an ALJ will be answered by the Docket Clerk.

Shirley M. Doolan
SHIRLEY M. DOOLAN
Hearing Office Administrator

APPROVED: R E Dockery Jr. DATE: 12-18-80
R. E. DOCKERY, JR.
Administrative Law Judge in Charge

EXHIBIT E (1)

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TO : All Personnel

DATE: December 30, 1980

REFER TO:

FROM : Hearing Office Administrator, Downtown Dallas Hearing Office

SUBJECT: Realignment of Personnel

Effective immediately, Hearing Assistants are reassigned to the direct supervision of the Hearing Office Administrator as follows:

Lee Herndon	-	Detached from ALJ Dockery Unit and reassigned to the Hearing Assistant Unit;
Billi Brown	-	Detached from ALJ Dockery Unit and reassigned to the Hearing Assistant Unit;
Ferne Bistany	-	Detached from any ALJ Unit and reassigned to the Hearing Assistant Unit;
Ella Mae Provazek	-	Detached from ALJ Stark Unit and reassigned to the Hearing Assistant Unit;
Danny Hill	-	Detached from ALJ Holland Unit and reassigned to the Hearing Assistant Unit;
Joan Starkweather	-	Detached from ALJ Brandes Unit and reassigned to the Hearing Assistant Unit;

A meeting will be held this afternoon at 1:00 p.m. to discuss the realignment, assignment of duties and relocation of work stations. Hearing Assistants and Hearing Clerks are expected to attend.

Shirley M. Doolan
Shirley M. Doolan
Hearing Office Administrator

approved:
R E Dockery Jr. ALJIC

EXHIBIT E (2)

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(Beginning of Reconfiguration)

TO : All Personnel

DATE: November 25, 19[illegible]

FROM : Shirley Doolan, Hearing Office Administrator, Downtown Dallas Hearing Office

SUBJECT: Temporary Realignment of Personnel

This will confirm that until further notice and in order to solve the emergency caused by the Hearing Clerk shortage in that office, the following steps have been taken:

1. Pamela Dowe, Melva Butcher, Edna Poafpybitty and Brenda Harris will spend 2¼ hours per day typing and/or mailing Judge Dockery's decisions and 5¾ hours typing and/or mailing their assigned Judge's decisions or such other work provided by their assigned Judges. (This represents a change in the original allocation on a case basis, and is made at the request of the various ALJs).
2. "Unlimited overtime" will be offered to Hearing Clerks and Hearing Assistants and others who desire to type decisions for Judge Dockery. Overtime will also regularly be authorized for units for other purposes.
3. The four "extra" Hearing Assistants will have to pick up the other work normally performed by Hearing Clerks. (other than typing and/or mailing decisions.) This work essentially is included in both position descriptions. For the time being, Mabel Phelps will provide extra help for Judges Martin and Brandes. Ella Mae Provazek will provide extra help for Judge Stark. Billie Brown will provide extra help for Judge Dockery. Ferne Bictony will provide extra help for Judge Holland.

All of these assignments and details are temporary and subject to change in whole or in part at any time where necessary to meet workload requirements.

No administrative assignments are changed. The HOA will see that cases are furnished for typing and will control the flow of cases.

It is contemplated this situation will resolve itself in a timely fashion and we can get back to a more traditional operation. Efforts are being made to obtain temporary typing personnel.

Shirley M. Doolan
Shirley Doolan
Hearing Office Administrator

EXHIBIT F

"Reconfiguration"

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals, SSA

TO : Hearing Office Survey (out) Team
Attn: Andy Hickam, RMO

DATE: March 17, 1981

REFER TO:

FROM : Jean Starkweather
Hearing Assistant

SUBJECT: Hearing Office Survey

I was not going to submit anything else to the Team in writing or otherwise. I am, however, writing one more thing to you to reemphasize a point. I have been advised this date that the HOA is still not giving priority to COURT REMANDS. She was asked point blank by a H.C. if she should type any court remands ahead of regular typing of decisions, and the HOA answered that this was not the case. The court remands were to be typed as the H.C.'s came to them in the drawers; such were merely interfiled with the regular cases. The same applies to mail-outs.

Since I am typing this to you, I will also add that the roster for February and March has not been followed as the HOA set it up on paper. Such shows that each ALJ was to be assigned Dallas cases, and this has not been done. Also, the extra hearing assistant has not been picking up the slack for other HA's on clerical or HA assignments. Instead such extra HA has been working on cases or work for ALJIC Dockery.

Jean Starkweather
Jean Starkweather
Hearing Assistant

EXHIBIT C

Danny

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

230 SOUTH DEARBORN STREET — ROOM 2848
CHICAGO, ILLINOIS 60604
(312) 886-5530

REFER TO:

OFFICE OF
HEARINGS AND APPEALS

January 20, 1981

Noe G. Garza
Administrative Law Judge
Office of Hearings & Appeals
Rm 222, Castle Hills Executive Plaza
1015 Jackson Keller Rd.
San Antonio, TX 78213

Re: Office Configuration

Dear Judge:

The Office Configuration experiment is a voluntary experimental program. The decision to become an experimental office is one for the ALJs of a particular office to make.

Yours,

F. J. O'Byrne
F.J. O'Byrne
Administrative Law Judge

cc: P. Brown, Chief ALJ

EXHIBIT 11

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration

During Reconfiguration

Memorandum

Date December 30, 1980

From Regional Commissioner, SSA
Dallas

Subject Office of Hearings and Appeals Request for Typing Assistance

To See Below

The Office of Hearings and Appeals, located in the Federal Building, has asked our assistance in processing their backlogged cases. Their need is for qualified typists. This involves transcribing hearings from recordings to written text using a mag card typewriter. While good typists are required, prior experience in transcribing or use of the mag card typewriter is not.

Services by our employees would be performed on an overtime basis, with work performed on Saturdays or in the evenings.

We request that you poll your clerical employees for volunteers for this project, and submit the names of your recommendations to Ken King or Mary Francis Duncan by close of business January 5, 1980. If you need further information, please contact Ken or Mary Francis at extension 7/4331.

Martha A. McSteen
Martha A. McSteen

Addressees:

Special Assistant, ORC
Director, Critical Issues Staff
ARC, Family Assistance
ARC, Field Operations
ARC, Management & Budget
ARC, Programs
    Director, Assistance Programs
    Director, Disability Programs
    Director, Insurance Programs
    Director, Systems Operations

RECEIVED
JAN 2 11 12 AM 1981
SSA, ORC
DALLAS TX

EXHIBIT I

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

: Jean Starkweather
Union Stewart

DATE: Janaury 21, 1981

REFER TO:

FROM : Melva Butcher
Hearing Clerk

Melva

SUBJECT: Dead Time

This is to inform you that again today, January 21, 1981, I sat for one hour with no work to do.

I notified Ms. Doolan, HOA, this morning that I only had one case to final along with the mailout that I was then about finished with. Each time I went to the HOA's office she was on the telephone (two times). I went and removed two cases for drafting so that I would not just sit idle. Ms. Doolan came to me and asked me if I was ready for some more work to do and I told her that I had gone and taken two cases. She said "You took two." I said yes. You were gone to lunch the last time I came to tell you I was out of work so I went and took two cases. She said that I couldn't cause I might get them out of order. I told her where I got the two cases from. She looked at me and walked out of the room(mag room).

EXHIBIT J

STATEMENT OF G. WADE GREEN, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

THE CASELOAD

Inasmuch as the reason for the increase in caseload is self-explanatory--i.e., more applications and now more cessations--I will not discuss the "why" of this problem. However, I will give you these observations: (1) More claimants are filing multiple applications--some even before exhausting their remedies, such as filing a new application while a prior case is pending at the district court level; and (2) A rather astounding percentage of applicants are individuals who have family members, particularly spouses, who are receiving benefits.

One suggestion in dealing with the increasing caseload is that we shorten our decisions. I do not believe an historical account of what has happened in a claimant's life, along with a repetition of the specific findings of record by way of physician's reports, is necessary for due process. The reasons why we have reached the conclusions we have reached is far more important; this is the feedback I have received from Assistant U.S. Attorneys. It may be that if an item isn't specifically discussed, it hasn't been considered by the ALJ (thus depriving due process); however, I have shortened my own decisions considerably and feel I can go further. Why, for instance, discuss an appendectomy or other acute ailments if a claimant does not contend they are significantly disabling? And even if he does, it should require no more than alluding to the fact that the evidence fails to establish the presence of complicating features that might be expected to contribute to the degree of disability. Nevertheless I also feel that an Administrative Appeals Court with appeals jurisdiction in lieu of that of the district courts is advisable. This suggestion is discussed further in my suggestions as to how to handle our problem of "inconsistency."

The ability to get decisions typed and mailed is clearly every bit as important as getting cases heard. Shorter decisions (with better reasoning) will require less personnel than might otherwise be required for typing and mailing. (Use of part time or lower grade personnel to assist our office workers in such time consuming functions as copying and mailing and assisting ALJs while in travel status are other ways of handling the backlog of cases from the standpoint of staffing but I feel sure the agency is at work on this and it need not be discussed here.)

I have left the necessity for increased ALJ staffing until last, inasmuch as I'm sure you have heard plenty about this as well as the A.P.A. standards. You have probably also heard the pros and cons of using staff attorneys or other non-ALJs to hear cases. Ideally, only ALJs should hear cases. If, on the other hand, the anticipated increase in the backlog of cases is seen as outstripping our ability to recruit qualified ALJs, then I suggest we consider a magistrate system similar, I think, to that used in the Department of Labor or the district courts, but one in which A.P.A. standards could be retained. It might work somewhat along these lines: After a period of 3 or more years on the job, a staff attorney would be eligible to apply to O.P.M. seeking placement on a "Magistrate" roster, one for which suitable standards would be specified in writing; among other things, the applicant's productivity, quality of work product, demeanor, and judicial temperament would be considered.

Cases would continue to be assigned to ALJs who would reassign, as needed according to the workload, cases to magistrates for hearing. Magistrates would issue "recommended decisions" eventually signed by the ALJ but with 30 days given to request review by the ALJ who might, if good cause is shown, rehear the case; the corps of ALJs would otherwise continue to hear cases as they now do.

INCONSISTENCY AND REVERSAL RATE

I have lumped these two problems together because I feel that some of their causes and solutions are similar, if not the same. Why the overall increase in the reversal rate in recent years? The primary factor I think is the increase in the caseload, leaving ALJs less time to properly develope cases, order consultative examinations, and the like. This applies at the initial and reconsideration levels as well. I recently received a cessation of benefits case and through my own efforts, added records of approximately 15 additional hospitalizations to the case file, reports that should have been obtained by the state agency. Failure to obtain proper documentation at whatever level of appeal leads to incorrect decisions that may or may not be corrected later on in the process. Thus the staff and the time to do the job are necessary. Cases often reach the hearing level with two or three physicians, some specialists, all saying the claimant is disabled. Few ALJs will then take the short statement issued by the DDS reviewing physician as sufficient to offset the opinions of the physicians who have seen and examined the claimant. The choice then is to pay the case or order a consultative examination. I hope you realize that sometimes the treating physicians rather than the DDS reviewing physician are right in their assessment. However, differences in the extent of case development contribute to the inconsistency of reversal rates.

Another factor is that ALJs, being lawyers, are quite attentive to the dicta of the federal courts, and even if at first they do not consider the dicta binding, after a few reversals of their decisions, they begin to apply it. Examples include: a treating physician's opinion is to be given great weight; pain alone may be disabling and need not be attended with positive clinical and laboratory findings (the wording of the Social Security Act notwithstanding); along with numerous District and Circuit Court opinions dealing with the shifting of the "burden of proof." The latter is a concept totally unrecognized at the initial and reconsideration stages. I suspect that many ALJs consider a reversal of their decisions by the district courts as reflecting on their competency; I also suspect that initial and reconsideration adjudicators do too, even though it is rarely done by an ALJ without new evidence. You should take this into consideration when you receive criticisms of the ALJs from the state agencies and DDS. This is not to say that we do not deserve some criticism; if I felt otherwise I would not take the time to make these suggestions.

The reason for the extremes in the high and low reversal rates is the differences in the manner in which ALJs weigh the medical and other documentary evidence and the credibility of the witnesses. Some skepticism is needed but there are a few ALJs who are too skeptical of testimony and treating physicians opinions. Their reversal rates may be too low. Others may be naive, gullible, or may enjoy being the "good guy" with a resulting reversal rate that is out of line on the high side. Additional training and counseling-- yes counseling-- should be done and I think it can be done, with the right spirit and in the right way, even under the A.P.A. This finally brings me to my suggestions.

1. Establish an Administrative Appeals Court.

A special court for administrative appeals should be established in lieu of appeals to the district courts. I suspect many district judges would like to get rid of this increasing burden anyway. Such a court would soon develop a degree of expertise in administrative or disability cases beyond that presently available. For instance, in the "real world" of disability cases ALJs soon begin to see reports from certain physicians who consistently say their patients are disabled no matter how meager the evidence or vice versa; this cannot help but affect the weight given their reports. ALJs and others who handle disability cases with regularity know that under ordinary circumstances such impairments as hypertension, diabetes, some types of heart problems, and degenerative arthritis do not ordinarily render an individual totally disabled, though they may well reduce the residual work capacity. It depends of course on their degree of severity. Mere diagnoses and a statement of a doctor that a claimant is "totally and permanently disabled" should not be sufficient, alone, to shift the burden of proof to the agency. The dicta of a special court should be more realistic.

I suggest that to handle the caseload, approximately four three-judge panels be established throughout the country, or more if necessary. Further, the agency or agencies whose cases they hear should also have the right of appeal. ALJs, I submit, would issue better decisions in the long run, and more consistent ones at that, if they know that consistent standards will be applied on appeal.

Assuming we still desire to pay benefits to individuals who are unable to work, wouldn't this be a fairer way to handle it or at least a method to try before going to totally objective standards, knowing that the state of the medical art is not that far advanced?

2. Place all ALJs under the Office of Personnel Management (I know this is not new but please read on.)

If all ALJs were placed under O.P.M. or in a separate agency, I'm sure that the various agencies would at first oppose such a move, thinking that they would lose control. But that's the point; they have little control at this time. Almost any criticism of ALJs is taken as a violation of the A.P.A. On the other hand, if the same criticism were made to O.P.M., in writing or to a special board, it could be weighed and appropriate action taken or the ALJ(s) defended as the circumstances warrant. O.P.M. or the new agency (I recognize the latter is probably an idea whose time has not come, though I think it is preferable) would "counsel" the ALJ if necessary. Decisions of ALJs whose reversal rates are suspect as being too high or low on a regular basis might be reviewed by our medical staff and additional training suggested if he appears to have little understanding of certain impairments. I know this is touchy but I think it can be done in the right way by a separate agency and certainly more readily than under the present system. I do not see the A.P.A. as a license for incompetency and, thus, I do not think the A.P.A. is our problem. It was meant to be a safeguard for the rights of citizens not a shield for ALJs!

Inasmuch as each ALJ corps has its own hierarchy, this plan should require no additional personnel and might require less. For instance, a group smaller than the present Social Security Appeals Council might serve to screen cases for appeal to the special court I mentioned in suggestion 1. Or they might retain their present functions if that be the agency's choice. A combined corps of ALJs could better be utilized than the separate systems we now have and with less travel costs in view of the various offices throughout the social security system. I would not recommend that all ALJs hear all types of cases; however, those desiring to hear cases beyond those they now hear should be required to establish their expertise by testing. In this way a multi-pay-grade system could be retained if desired.

OTHER SUGGESTIONS

1. Insure adequate funding for medical consultants.

2. Encourage greater participation of the medical community in the program as consultants, particularly the specialists.

3. Appeal district court decisions when this action is warranted.

4. Encourage better understanding among the individuals in the state agencies, DDS, and OHA.

5. Consider expanding the introductory comments of each section of the Listing of Impairments to include discussions of various impairments, in particular those most commonly alleged as disabling, in such a manner that the comments could be used in decision writing to point out why a physician's report fails to meet the burden of proof. This would reduce the need for consultative examinations in cases where a "severe" impairment is obviously not present or where the physician has obviously overstated the reduction in functional capacity.

6. Take great care if instructions on how cases are to be handled are issued by the agency (such as the proposed "POMS") in order to insure they are not in conflict with the Social Security Act or regulations, thus raising the possibility of large numbers of remanded cases on top of an already large backlog of cases.

Paul Harkey
P O Box 222-122
Dallas, Texas
75222

November 2, 1981

Hon. J. J. Pickle, Chairman
Social Security Subcommittee
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Pickle:

While this is in the form of a letter to you, I am typing it double spaced, attaching a short biography and making five copies. If you should determine it has sufficient merit, you can incorporate it in the record of your October 23 and 28, 1981 hearings on the case review and Social Security appeal process.

The Social Security eligibility and termination hearing process continues to expand like "topsy". All effort of the Congress to insure its validity and accuracy begins with the assumption that the volume of cases will continue to increase and nothing can be done which can reverse the trend. This assumption is error. If the abuse of the system can be reduced, the volume of cases to be heard can be drastically lowered.

The basic problem is that every component of the Social Security Administration continues to be vigorously engaged in "empire building". The Social Security Administration meticulously follows the Laws published some three decades ago by Lord C. Northcote Parkinson regarding the expansion of organizations: The number of employees will expand to fill available space, and the work will increase to utilize the additional employees. Every aspect of every action and non-action of the Administration has built-in systems to increase the work load.

Many of our current problems and current waste exist by continuing to blindly follow concepts which were adopted when administration of the Social Security Act was following a much different philosophy of government's relationship to its citizens. An administrator can have a different philosophy when there is money to spare from what is necessary when the cupboard is bare.

It had been my belief this trend would halt when the money ran out. Even now, when faced with bankruptcy of the Trust Funds, the attitude continues to be "after all, it is just money", and empire building continues.

I make no apology for the personal observations, reactions and opinions expressed herein. I do not, and judges should not, keep statistics. Most of my suggestions are based on inadequate data and much of the inspiration for suggestions is based upon rumor and an understanding of the existence of a situation which may, in fact, not exist. Communication inside the Social Security Administration has never been complete and different components maintain rivalries with and preserve secrets one from the other. It has not been my privilege to observe the Administration of the Act from either the bottom or the top, but rather from the bottom over at the side. We are flooded with information which is totally irrelevant to our duty and bereft and denied information which is sorely needed.

Through the end of World War II, most of the administration of the Act consisted of issuing account numbers, creating files and recording employee/employer taxes. At the end of World War II, there were sufficient fully insured citizens that the system expanded tremendously and benefits were being paid. During this expansion, the Social Security Administration hired some of the most capable persons who have ever been civil servants in the United States. Many who entered military service directly upon college graduation, many who had short prior careers as educators, accountants, insurance trainees, and business graduates became employees in the Social Security Administration.

During the almost three decades following World War II, the Social Security Administration earned and deserved the reputation as the elite organization in the federal government. As it matured, it began to lose its commitment to public service and institutionalization set in with resultant empire building, turf acquisition and the arteriosclerotic hardening of the monolithic, bureaucratic structure it now is.

Since it was a program of social insurance based upon proof of coverage, age and beneficiary relationships, its administration was objective and permitted precision in eligibility determinations. Since coverage was an initial threshold for eligibility, it was possible to make predictions and evaluations with adequate accuracy. Determination of credibility and evaluation of testimony of an applicant presented few problems in the administration of the Act.

When after a satisfactory trial run on the wage freeze (Period of Disability), cash benefits for disabled persons was enacted, the system began to deteriorate. Prior to this, the only need for investigations involved the acquisition of records and occasional unannounced home visits to verify the physical existence of the alleged family relationships. The Social Security Administration has never been oriented into any type of investigative activity or case work. Applicants were awarded disability benefits based on their own assertions and the assertions of their family physicians. The only control was the occasional utilization of an examination report from a consultative physician. Even that system was reasonably satisfactory when disability benefits were awarded only to those whose impairments would end in their death or be of long continued and indefinite duration -- it did not falter too much when the limitation to only those over age 50 was eliminated.

During these times, the Trust Funds accumulated so many FICA tax dollars that benefits were expanded and every expansion by law was followed by a further expansion in administration which then justified a further expansion by law. When temporary disability benefits were enacted, prudent administration cried out for investigations, but the popular concept was that poor people would not lie and that was used as the justification for inaction.

Since that time through the different community action programs, neighborhood organizations, legal service corporations, etc., persons financed with federal funds have held training sessions on how to make application for Social Security payments, Supplemental Security Income, a myriad of loans and food stamps. These lectures have been most explicit not only in regard to how to lie, but what lies to tell and what truths to keep secret. The philosophy of never questioning the accuracy of an assertion by an applicant remains so fixed that even when a disability adjudicator is certain in his heart the case is full of perjury, no investigation is permitted and the liar prospers on his ill gotten gain.

H. R. 1 in the first Nixon Congress was designed to straighten up the mess in the program of Aid for Families with Dependent Children. When H. R. 1 became law, it did not concern AFDC, but placed aid to the aged, blind and disabled on a national basis. It was intended to standardize payments nation-wide thereby abolishing the great difference in the payments in the various states. The Social Security Administration was not an illogical agency to administer Supplemental Security Income. Instead of realizing that the administration of a welfare program was much different from that of an insurance program, SSI was merely piggy-backed onto Title II and administrative problems have compounded ever since.

Coincident with adding the administration of Title XVI to the administration of Title II, two other trends developed which have reduced efficiency tremendously. The dedicated, capable senior employees who had been the stalwarts in the Social Security Administration became eligible for retirement. With what they perceived as increasingly inept leadership and increased local pandemonium, they retired. The expanded work force did not receive training and indoctrination from the best but only from what was left of the best.

New employees were recruited with full equal employment fervor and it was much more important that balancing quotas be accomplished than that new employees be capable. SSI was to be handled mostly by computers. This was the system that was almost to capacity when it was required to drop the five lowest years of reported earnings in order to calculate the Primary Insurance Amount for a retiree. The newly recruited employees were supposed to learn to operate the computer terminals in sixty days. During that time, one outstanding District Office Manager told me that while they could teach one of the kids how to operate the computer terminal in sixty days, it took two years for a competent person to learn how to carry on an intelligent conversation with the computer.

The most urgent need for improvement in the administration of the Act is to immediately begin installing a modern computer system and at the earliest possible date store in it all the information needed for administration of the Act. The failure of the system to credit 1978 earnings for members of the Air Force or the Employees of Western Union is bad enough; it is correctible. The payment of hundreds of millions in benefits to deceased Title II and Black Lung beneficiaries is intolerable. Most of the problems with overpayments and hearings required on them would never happen if the computer system were modernized.

I have never seen any statistics regarding recoupment of overpayments which cannot be deducted from future benefits, but it must be negligible. Duplicate Title XVI and Title II payments have been immense, but I have never seen any published statistics and I doubt if any audit could possibly disclose their enormity.

WORK UNIT POINT SYSTEM

I first heard of the "Work Unit Point" system from a lady who had been a Hearing Assistant in the Bureau of Hearings and Appeals and became a Claim Representative in a District Office.

One of her first interviews was with a man who came in to apply for Title II disability benefits. The interview disclosed clearly the gentleman was a floating derelict who had in no way ever worked in covered employment a sufficient period of time to be even close to being insured for disabilty purposes: She so advised him. Satisfied with her explanation of this threshold requirement, he left the office. She was immediately verbally assaulted by the Assistant Manager who told her in no uncertain terms that never was she to permit a person who inquired about disability benefits to leave the office without her taking an application. He told her that she had just thrown away nine work unit points. She attempted to explain there was no way the interviewee could meet the earnings requirement and he informed her that the situation was the easiest points of all, for it could be denied without her having to even assemble any medical information regarding the case.

At the February 1979 Conference where former Commissioner Stanford Ross was discussing the use of attorneys to represent the Secretary in hearings which were actually adversary hearings, the Administrative Law Judges present told him how the work unit point system resulted in tremendously increasing the numbers of Requests for Hearings. Neither Commissioner Ross nor Associate Commissioner Trachtenberg had heard of the system. It was several months, and after diligent inquiry, that Associate Commissioner Trachtenberg was able to trace down its existence.

I have never seen the system explained in print. No mention of it is made in any of the many manuals in this Hearing Office. My information may be pure myth. My hearsay information is that it is very real and is the controlling factor in the operation of District Offices.

The Work Unit Point system was adopted after careful analysis of the operations performed in the District Offices, the amount of time required for each operation, and how individual tasks related to the total need for staffing of each District Office. It basically consisted of a point for each individual document which needed to be prepared. An example would be that in a simple application for retirement benefits, one point would be assigned for filling out the application, one point for the proof of age and one point for proof of earnings, making a total of three points. The accuracy of this work was easy to determine and Payment Centers would, on a regular basis, assign percentage of accuracy grades to each District Office regarding the processing of applications.

In the early days of disability benefits under the Act, much more paper work was required in processing a disability application and the total initial work unit point award was nine. This included application, proof of earnings, work history, medical history, accumulation of medical information from prior treatment sources, ancillary applications with proof of relationship, etc. The disability interview was a narrative report which included personally dictated paragraphs on specific areas -- probably up to about fifteen. These essay type, narrative interviews were so good that I would enjoy recognizing a claimant in a crowd at the County Court House when I was holding hearings. It gave excellent background to the adjudicators who had to determine eligibility/non-eligibility of the claimant for benefits. The Claim Representatives on behelf of the District Office well deserved the Work Unit (Brownie) Points which were awarded.

The quality of the initial claim file began to deteriorate rapidly after a printed form was substituted for the in-depth, essay type, narrative interview. The quality further deteriorated with "Simultaneous Development". This innovation was designed to speed claim processing. It consisted of the District Office developing the "non-medical" aspects of a claim and the State Agency assuming the duty of developing the "medical" aspects of the claim. Each component determined what was medical/non-medical, resolved all questions in favor of the other component having the responsibility and much important information/evidence never was acquired for the claim file.

Even a decade ago, it was relatively rare to have a hearing on a case involving an application subsequent to the first application. Today it is a pleasure to receive a relatively thin file on a first application with a straight-forward, genuine impairment. Claim files received following a Request for Hearing too often contain multiple prior applications and it is a time consuming task to separate out the documents which should be proffered as exhibits in the hearing record. On one recent 15 case docket, the 15 files were a total of 39 inches thick and weighed 52 pounds. The problem of preparing the cases for hearing is compounded by the fact that it is most difficult to even speculate regarding the position of the Administration: The reason for and the documents upon which the determination was made to deny or terminate benefits. It is most difficult to protect the position of the Administration in the hearing process when the position of the Administration is unascertainable.

Since the size of a District Office, including the numbers of employees and their pay grades is determined by the total accumulation of Work Unit Points, the employees in each District Office have a vested personal financial interest in accumulating the maximum number of Work Unit Points. When a claimant receives a denial of the claim, it is in a tasteless, anonymous, Mother Hubbard form which contains absolutely no information regarding why the claimant was not found eligible nor any indication the denial pertains to that specific claimant. Many claimants come to a hearing believing the Administration has confused their name and number with some other claimant.

Each denial or termination notice is accompanied by a detailed road map telling the claimant how to appeal the adverse determination. This is a hang-over from the paternalistic administration which led every claimant through the full process. It is quite outdated in an era when claimants have been informed by every possible manner imaginable of their rights or where they are represented by attorneys who are expecting a contingent fee. If a claimant does not quickly respond to the denial by going to the local District Office, the claimant is phoned and requested to come in. When a denied claimant appears, a Request for Reconsideration, Request for Hearing, or a Request for Review is taken; the two Work Unit (Brownie) Points are accumulated and as soon as the claimant has executed the Request, he/she is dismissed as rapidly as possible. If a hearing is requested, the file is forwarded with no additional work on it: The District Office receives the Brownie Points and it is a situation of "off my desk and onto yours".

If inquiry is made by a denied claimant and there is a possibility of taking a Request, the claimants are urged and cajoled into signing a Request. Several years ago when Title II benefits were increased automatically and SSI benefit increases lagged until the statute was changed, I had two persons testify at the beginning of their hearing they really did not want a hearing; they had made inquiry regarding the reduction in their SSI benefit and were told at the District Office that they were prohibited from explaining why the SSI benefit was reduced; that if they wanted an explanation, they had to request a hearing and it would be explained to them at the hearing. This resulted in the award of "brownie points" to the District Office at a cost to the Trust Fund of providing hearings.

When the Texas Department of Corrections classifies prisoners, those with impairments are assigned to the Wynne Farm Unit. When our hearing office serviced the prison, every hearing reoord of a claimant at the Wynne Farm began with Exhibit One being a letter from the District Office informing the claimant that he might be eligible for Social Security cash disability benefits; if he desired them, sign below, mail it postage free and some one would come to the prison and take his application.

Those prisoners always went the full hearing process. Even if they knew it was hopeless, they were permitted to "lay in" a half day each time the Social Security employee visited the prison and "lay in" a full day when they had their hearing. I never found a prisoner eligible, but the District Office kept me busy so it could collect the "brownie points".

There is far less time and effort needed to process a subsequent application for disability benefits than to process the initial application. On subsequent application, many of the forms are merely "headed up" and then in the spaces which require information, only the notation is made "see prior file". The Work Unit Points are much easier to obtain than in the initial application. That is why personnel in the District Office call up claimants and suggest they come in and file a new application when the District Office receives its copy of the hearing decision denying benefits.

The Work Unit Point system should be abolished for all cases which involve eligibility for benefits based on disability. It is impossible to impose any type of quality control on the operation or to discourage District Office employees from working diligently to accumulate Work Unit Points. If there were no financial incentive to receive applications and to keep repeating the long ladder of guarantees of "due process" in the hearing process, such a significant reduction in Requests for Hearing would be realized there would not exist the increasing hearing load. The current numbers of persons engaged in the hearing process would be more than adequate to handle the new Requests for Hearing.

The Work Unit Point system can be abolished in all disability applications by a mere order of the Commissioner. There is no need for any amendment of the Act nor the Regulations.

"REVERSAL RATES"

A disability adjudicator can award benefits in 100% of a sample of cases or deny benefits in 100% of a sample of cases and every decision be an accurate decision; conversely, the disability adjudicator can award benefits in 50% and deny benefits in 50% of a sample of cases and every decision be erroneous. The only rate of denial/allowance with which an adjudicator should be concerned is whether his actions are consistent with the national results and the relationship in his own area where a statistical sample can be valid in comparing the adjudications of others and of the judge himself.

It is impossible to compare adjudication determinations at the initial and reconsideration levels with adjudications at the hearing or review level. Proper administration should require that a national program attain an equal result throughout the entire nation. If any individual or component is utilizing standards or attempting to exert control which is not consistent with the Act and the Regulations, then corrective measures should be taken to correct inequity or improper results.

When I was a member of the Policy Council of the Office of Hearings and Appeals, I maintained that the one thing which we should not and could not successfully defend or explain was significantly inconsistent reversal rates over a reasonable statistical period from judges who were assigned cases in a random manner from a common pool. It is a source of embarrassment to every honorable, conscientious judge. Our hearing system should and can be so objective that, with minor variations, all judges should make the same decision on the same record. Under the current system, it constitutes an act of courage for a judge to write a decision denying benefits.

When something is conceived in sin and brought forth in inequity, it is difficult thereafter to give it adequate baptism or dedication. Title 5, United States Code, Section 557(c)(3) states:

> ". . . The record shall show the ruling on each finding, conclusion or exception presented. All decisions, including initial, recommended, and tentative decisions

> are a part of the record and shall include a statement of:
>
> (A) findings and conclusions, and the reasons or basis therefor, on all material issues of fact, law or discretion presented on the record; and
>
> (B) the appropriate rule, order, sanction, relief or denial thereof."

In spite of that clear mandate of the Administrative Procedure Act, for "expediency", judges not only do not follow it, but a slothful judge can issue a decision awarding benefits by filling out one of six pre-printed, manifold forms which require only that from one to four blanks be filled in with dates. He then can file a secret justification which can be as short as one sentence. This is not only condoning, but is actually encouraging judges to utilize reversals to escape their duty as a judge.

If a judge decides, instead of writing a lawful decision, to merely fill in the month and year on Form HA-5143(SSI)U7, he is through with that case. There will be no review, no Appeals Council remand, no District Court Civil Action and no sequelae. He does not even need to look at the tables and rules contained in the Medical-Vocational Guidelines in the Appendix to Subpart "P".

If he meticulously studies his case, articulates a decision which reveals he listened carefully to the testimony of an applicant, explains the medical evidence which is significant in the case, sets forth cogent and compelling reasons for the decision, makes his specific findings on all material issues of fact and law (in an ordinary disability case, there are from 13 to 19 material issues of fact), and makes an accurate decision, he then becomes the "defendant" in the case. He is well identified, for the judge is the only person who has to sign the decision and set forth his location. He has no advocate to defend him. He is remanded or reversed without being informed why his decision was in error. Statistics are maintained which reflect on his "production". He becomes an "also ran" in the numbers game. If judges and appeals council members were required to spend as much effort in throwing away tax dollars as they do in seeing them awarded only to eligible persons, the incentives to achieve the "untenable reversal rates" would be severely reduced. It boils down to the fact that since the Office of Hearings and Appeals decided to violate the clear mandate of the law regarding the contents of an administrative decision, it reaps the whirlwind it has sown.

APPEALS COUNCIL

The Appeals Council currently has the most members in history. Many employees are on the support staff in different roles. It continues to "empire build" and justify its existence.

As the "Review Board" for the Secretary (Agency), it has two major purposes: (1) To implement and execute the policy of the Agency (Secretary) and (2) to insure that the Act and agency policy are evenly administered nation-wide. The sole work product seems to be the attaching of a printed form affirming the decision of the administrative law judge or issuing a remand order to the administrative law judge. Probably worse than any appellate tribunal in the nation, many of its orders reveal a total lack of understanding of its function and an absence of any knowledge of the hearing process or of the "real world". Not in the past decade have I read a "Decision" from the Appeals Council which indicated the Members of the panel had any knowledge of the specific case in which the Decision or Order was written.

Every lawyer and judge in the nation, worth his salt, knows of what "Res Judicata" consists. The doctrine of "Res Judicata" is consistent in every jurisdiction! It simply means you cannot try the same case more than once. Title 20, Code of Federal Regulations, Section 404.957(c)(1) is consistent:

> "The doctrine of res judicata applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination has become final by either administrative or judicial action;"

Each time an administrative law judge dismisses a Title XVI case under the doctrine of "*res judicata*", if there is a single day between the new application and the date of the final denial, the Appeals Council holds that the one day constitutes a different issue and remands the case for hearing; if there is a single day of insured status coverage in a Title II disability benefits case, the holding is the same, the case must be heard for the one day makes it a new case. This is just a silly method of empire building and gaining statistics to document the necessity for the existence of the Appeals Council.

It has the same attitude for increasing the case load by almost always setting aside a dismissal which is filed after the time for appeal has expired. Not only do District Office personnel furnish tardy claimants with the reasons for their "good cause" to get the "brownie points", but the Appeals Council upholds them.

These two problems could be solved by the Associate Commissioner for the Office of Hearings and Appeals informing the members the empire building is to stop and they must follow the Regulations on res judicata and legal filing. If this were done, the hearing load would be reduced by numbers in the thousands.

PROMPT PAYMENT/PROMPT APPEAL

When benefits are awarded, even the Award Certificate states that if the recipient is not satisfied with the award, full appellate rights attach. In over one case out of forty, claimants receive their past due benefits in a lump sum and then begin the appeal process to receive more past due benefits by contesting that the date of onset should have been earlier. Unless the judge makes eligibility itself an issue and forces the recipient to go for the "whole ball of wax" again, the recipient eats his cake and then appeals for more. If claimants were not paid their past due benefits until after their appeal rights expired, or were required to waive their appeal rights before they receive the check for their accumulated past due benefits, the hearing load would be reduced at least another two percent.

UNANNOUNCED HOME VISITS

The unannounced home visit was utilized by the Administration in days gone by. A Field Representative would appear at the home of an applicant or a beneficiary unannounced, where with proper courtesy and consent, he would conduct an interview. Observations made which excited the curiosity of the Representative would be pursued. The information obtained was most valuable in determining whether the applicant was eligible or the recipient continued to be eligible.

In disability cases, particularly in cessation situations, a simple "unannounced home visit" would be an extremely inexpensive and accurate method for assisting in the determination of original or continued eligibility. One good Field Representative can make many unannounced home visits for less cost than to purchase even one consultative medical examination for prospective cessation.

ADMINISTRATIVE LAW JUDGE

The Constitutional Republican form of government of the United States of America is probably the finest system for men to live together in freedom which has ever existed on earth. It has been tried in the crucible of civil war and wars abroad. It has continued to exist by the consent of the governed citizen. It has flowered due to the unique propensity of the average American citizen to accept the result of a majority voice expressed in a public action and willingness to accept an adverse personal decision if first the citizen can make his voice heard in a forum which has the power to correct the alleged injustice.

Philosophically, the third level of adjudication of a claim for Social Security benefits must be conducted under the requirements of Section 205 of the Social Security Act, 42 U.S.C. 405, and Section five of the Administrative Procedure Act, 60 Stat 237, 5 U.S.C. 554; they are not inconsistent and both provide the same due process of law, Perales v. Richardson, 402 U.S. 389. This process has proved to be a wonderful safety valve in American society. It has many times proved its value in preventing disgruntled, distraught or insane claimants from throwing rocks through the plate glass windows of the Social Security Administration District Offices or assassinating the local managers thereof. The soothing and healing effect of the "fair hearing" has maintained the "peace throughout the land".

The merit system examination system administered by the Office of Personnel Management together with the safeguards which guarantee each citizen that the Administrative Law Judge who hears his case has absolute decisional integrity has resulted in what must be viewed historically as the most progressive, simple, effective and accurate system ever devised for the termination of a quarrel between a citizen and his government. The Baltimore Studies established when claimants adjudged in disability claims by Administrative Law Judges were investigated five to seven years later that the decisions of the judges made after hearings had proved to be astonishingly accurate.

The simplicity of the hearing procedure and the quality of the Administrative Law Judges has resulted in the disposition of huge volumes of litigation in a highly satisfactory and most expeditious manner. Much of this has been accomplished not because of, but in spite of a total lack of understanding by the transient political leadership of litigation problems and the hearing process. The success has been due to the capability and integrity of the Administrative Law Judges and their approach to each hearing as the most important event in the life of each individual claimant.

Horrendous work loads force even the most steadfast to cut corners and slight details -- heavy work loads effectively dilute the quality of due process of law.

There are two basic differences in the responsibility and duty of an Administrative Law Judge employed by the Social Security Administration and those employed by the other thirty federal administrative agencies which employ Administrative Law Judges: 1. In the other agencies, no case ever reaches the hearing level until a responsible agency official determines by positive action or by communicated inaction that the agency considers that specific case ready for hearing; the Social Security cases go to hearing because they are not ready for hearing and the agency action has not been properly completed. 2. The Social Security Administration Administrative Law Judge works in an absolutely non-adversary situation; he is the Advocate for the appealing citizen, he is the Defender of the Trust Funds, he is the independent fact-finder and decision-maker. Presence of counsel for a claimant does not relieve the Social Security Judge from any of his obligation to assist the claimant as his most competent advocate.

When a mortal, even though he may be well trained in the law and of robust health, is overworked and without hope of surcease, there is deterioration of his effective work across the board. A harrassed and careworn judge cannot be as alert and sensitive to the nuances regarding the evidence of an inarticulate claimant as one who is concerned with only the specific claimant at that hearing. The quality of counsel in the typical hearing cannot supply that deficiency.

After the enactment of the Social Security hearing procedures by the Congress, the Social Security Administration employed Referees. It required ten years of sustained effort on the part of the Civil Service Commission, which was given that duty by the Congress, to force the Social Security Administration to bring its Referees under the protection of Section Eleven of the Administrative Procedure Act, 5 U.S.C. 3105. The Social Security Administration has always resented its inability to require predetermined results in the Hearing Decisions and to place its' Administrative Law Judges on a production quota basis. All criticisms of the administration of the Social Security Act have been answered by pointing an accusing finger at the Administrative Law Judges and diverting the criticism away from the actual cause. The Administrative Law Judges historically have been and currently are the true Biblical "scape goats" for the inadequate administration of the Social Security Act. In a proper judicial manner, the Social Security Administrative Law Judges have absorbed this role and continued to perform their duties as good citizens and dedicated public officers.

The corps of Hearing Examiners/Administrative Law Judges have been in an emergency/panic situation for the past quarter-century. In the late 1950s, cash payments for disability were enacted. The load was so heavy that temporary Referees were required. The Corps worked the problem away in about three years. In 1965, the Congress created Medicare and changed disability eligibility from permanent to temporary. Again the Hearing Examiners eliminated the heaviest backlog in the then history of the Administration.

Without consultation with either the Social Security Administration or its own Committees which had jurisdiction over Social Security legislation, the Congress enacted the Federal Coal Mine Health and Safety Act. This placed a case load of some quarter million cases on the shoulders of the Judges in addition to their normal work load. Judges from across the nation went into the coal fields and surmounted that burden. The light at the end of the tunnel was bright! Congress amended the Act and required that all previously denied cases be readjudicated; the Corps again rallied and disposed of those cases.

After H.R. 1 of the first Nixon Congress became law and the federal government relieved the states from administering the joint federal-state-grant program of aid to the aged, blind and disabled, the Social Security Administration built up a backlog of some 200,000 denials ready to release with full knowledge that most of them would go to hearing and then dumped them on the Administrative Law Judges during a period of a few months. At that time, now United States District Judge Dale Cook was the Director of the Social Security Bureau of Hearings and Appeals. He finally received approval to hire additional temporary Supplemental Security Income Hearing Examiners as he had the temporary Black Lung Judges. Again an augmented Corps conquered the backlog.

The history of the use of Hearing Examiners/Administrative Law Judges by the Social Security Administration is one of a succession of miracles performed by outstanding, dedicated public servants under crisis conditions.

While even under the current docket conditions, the lapsed time statistics of the Administrative Law Judges of the Social Security Administration compare most favorably with the conditions of any court system in North America, these judges during their relatively few periods of normal work loads accomplished phenomenal results. Between the disposition of the health care and temporary disability onslaught and the black lung cases, some offices of Administrative Law Judges had mean case disposition rates of as low as 21 or 23 days from the receipt of a Request for Hearing until a Decision was issued. Many judges still in active service dream about the "good old days" when they would get a

Request for Hearing, about a week later would receive a case file, hold the hearing and issue a decision with a mean elapsed time of 35 to 45 days.

Adequate, competent staffs and good word processing equipment will make a judge more productive. Judging itself cannot be delegated or mechanically attained. The judge pre-hearing must himself study his cases as fully as a trial lawyer does before he appears in front of a jury -- otherwise, he cannot fully cover the necessary issues and facts in the hearing.

The hearing must be adequate and claimants must believe they are not rushed. After the hearing, the judge must digest the evidence and engage in all the cerebral processes needed to make an accurate decision. This process must be reflective, comprehensive and serene.

As you know, my career has been most fruitful and pleasant. I have always felt compatible with the quality of my service and the condition of my docket. It is based on experience when I say that no competent, conscientious judge can average more than one completed, proper case per day over any sustained period -- addition of expensive personnel or sophisticated equipment cannot make judges "Merlin the Magician".

REPRESENTATION OF CLAIMANTS

The Social Security non-adversary Appeal System is probably the most efficient "due process" trial system in the United States. It was designed to make the process simple, fair and expeditious. The attorneys discovered the fat fees in the cases where all that was required of them was to attend the hearing and go through a litany of questions which has been published in some books and in the manuals of the Legal Services Corporation and the National Legal Aid and Defender's Society. The administrative law judge and his hearing staff do all the work. The purpose of a trial or a hearing is the conduct of "the search for the truth". During my career as a Hearing Examiner/Administrative Law Judge, less than one case in five hundred has involved a fee seeking representative who was of any assistance in "the search for the truth".

While the Sixth Amendment to the Constitution originally contemplated the right of counsel in only criminal cases, such right is now so much a part of "due process" that it cannot be denied. The policy manuals and internal operating procedures of the Office of Hearings and Appeals should be amended so that when a claimant is represented by counsel, it should be recognized that it is an adversary situation and such counsel should be required to perform the same amount and same quality of work which would be expected of him before any other agency or in any state or federal court in the land. Countless hours of valuable judge and hearing staff time are consumed in furnishing the same assistance to fee seeking lawyers which is normally afforded a non-represented claimant.

In the early months of 1979, Commissioner Ross proposed the adoption of adversary hearings. His ideas were simple, straight-forward and most necessary. Stanford Ross is a most outstanding lawyer and he recognized the need for the Secretary to be represented in the truly adversary hearings. By the time the proposal was "staffed", logistic requirements determined and a whole slew of new Regulations proposed, the experiment was so bloated, top-heavy, misconceived and unwieldy it could have never worked. I was personally relieved when Secretary Harris shelved the project it would have been a miserable failure which would have scored against the idea instead of its unrealistic attempted execution.

In many hearings, probably a tenth of them, the Secretary does need representation. The administrative law judge cannot do an adequate job of cross-examination of claimants and witnesses where there is perjury and fraud present without losing the detached attitude and appearance necessary for an impartial arbiter. Also, if the Secretary were represented, some of the attorneys representing the Secretary would probably make some discreet inquiry or even some personal observations which would materially assist in placing the truth in the hearing record. If some of the less able fee seeking lawyers knew they would face a real opponent before the judge, they probably would not pursue their contrived cases to the hearing level, thus further reducing the case load.

Neither the Act, the Administrative Procedure Act, nor any Regulations need be changed to permit the Secretary to be represented in the hearing process. Most hearings are not adversary in nature. There is an appearance of unfairnes if the Secretary is represented in a case and a claimant is not represented, so discretion should be observed in selecting the cases in which the Secretary is represented. There are three situations where the Secretary should be represented:

1. All hearings pursuant to a remand from the United States Courts.

2. All hearings where any component of the Administration desires representation.

3. All hearings where the administrative law judge is of the opinion the truth will be obscured if the Secretary is not represented, and in his discretion issues an Order requesting representation.

There are now adequate numbers of attorneys employed by the Social Security Administration and in the Office of General Counsel of the Department of Health and Human Services to represent the Secretary under those three conditions without sacrifice to their other duties.

In summary, the crisis of the tremendous anticipated hearing case load can be eliminated if each person employed by the Social Security Administration will perform his duties right the first time around.

The specific recommendations mentioned herein are:

1. Abolition of work unit points in disability cases.
2. Understandable, personal, informative initial denials.
3. Understandable, personal, informative reconsideration denials.
4. Unannounced home visits to applicants or recipients.
5. Actions of denial firmly documented in the claim file.
6. Representation of the Secretary, where appropriate.

7. Adequate and thorough hearings.

8. Proper hearing decisions which meet the requirements of the Administrative Procedure Act.

9. Proper execution of its function by the Appeals Council.

Execution of them would so reduce the hearing load that less than the numbers of Administrative Law Judges currently employed by the Social Security Administration would be adequate to dispose of all Requests for Hearing within 60 days from filing. None of these suggestions would require any action, except oversight, from the Congress and none of them would require amendment to the Regulations.

The simplest method of encouraging employees of the Social Security Administration to devote proper attention to each case would be to have administrative law judges remand a case to the Administration when that case has not been properly prepared for a hearing on the issues which will be presented on appeal. Currently employees, even the receptionist, of the District Offices can remand cases to the component from whence it came. Members of the Appeals Council can remand cases. All judges on 42 U.S.C. 405(g) review can remand cases for added preparation or what the remanding employee or Judge desires: Administrative Law

Judges have been denied that power to freeze them in the roles of the "wipe-up hitter" and the "scapegoat".

Past crises have been met only by the Administration hiring more people and spending more F.I.C.A. tax money. The time is now to eliminate all the internally generated causes for the hearing load. If applications were properly processed and the job done right the first time, every time, there would be no hearing process crisis.

If our precious Social Security system is to remain viable, these reforms must be attained.

Respectfully submitted,

Paul Harkey

Paul Harkey
Administrative Law Judge
Dallas, North

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Marilyn C. Newhouse
Specialist Attorney

November 6, 1981

Representative J. J. Pickle
Chairman, Social Security Subcommittee
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C.   20515

Re: October 23 & 28 Hearings

Dear Chairman Pickle:

I understand that the Social Security Subcommittee held hearings last week to consider a variety of issues concerning the Social Security appeals and case review process as well as the proposal to create a Social Security court. As an attorney who has practiced in this area for nearly six months, and as supervisor of thirty-eight paralegals in Alabama who practice as representatives before the Social Security Administration, I offer the following comments on these issues.

Our federally-funded program provides free legal representation in civil matters to low-income Alabamians in sixty of the sixty-seven counties in the State. Because it is more cost-effective to use paralegals in administrative law cases, and because the regulations of most federal agencies permit non-attorney practice, LSCA has since late 1977 trained and supervised paralegals in Social Security practice for our clients. A typical paralegal handles over forty cases in a given month, with a good majority being in the area of Social Security disability claims. It is our unaminous opinion that the adjudication and determination processes have recently become so burdened that they interfere with the due process rights of our clients. Backlogs in the Offices of Hearings and Appeals covering our State are increasingly significantly; a delay of six months from hearing request to hearing is common. This is particularly tragic in cessation cases where often the State Disability Determination Unit is relying upon negligible medical evidence, or none at all, as justification for terminating a claimant's benefits.

The disparity in treatment of cases by the State Disability Determination Unit is striking. Apparently, in an effort to complete redetermination of claims of several years standing in a short period, DDU is understaffed and illtrained to adequately evaluate medical evidence. DDU analysts are giving claimants only a few days in many cases to provide additional evidence proving beyond any doubt that they continue to meet SSA disability standards, and in many cases determining that claimants no longer are disabled when the evidence provided is substantially the same as in the past. Typical cessations in our experience the last few months are those of younger claimants with severe mental impairments and older claimants with a combination of impairments, although one or more of these impairments may be quite serious. Once DDU makes its decisions, it may take up to a year to obtain review by an Administrative Law Judge, where reversal is common. Benefits are not payable during this time period, except in SSI cases where an appeal is taken within ten days.

For example, I currently represent a client who is expecting a hearing in December. She is a fifty-eight year old woman with over thirty-five years of work experience. Two years ago, she was placed on disability benefits because of uncontrolled hypertension (despite heavy medication), arthritis, heart complications, obesity, and severe asthma. Entitlement was established following the report of a SSA consultative physician verifying the severity of her medical condition. In March 1981, she was reevaluated and another consultative physician indicated that her condition continued to be serious, particularly in regard to her hypertension. I have been unable to locate a blood pressure reading in the last five years where her diastolic reading was below 110; it is often as high as 140. Within three weeks of the consultative examination, she was hospitalized for severe asthmatic bronchitis with a blood pressure reading of 230/140. Her blood pressure remained extremely high during the period of her hospitalization, and an EKG revealed that she had suffered an anterior myocardial infarction apparently during her asthmatic attack. Upon her discharge from the hospital, she received a notice from SSA that her benefits were being terminated becuase her medical condition had (sic) improved. As I said, she is still waiting for a hearing on her appeal, and it may be several months after the hearing before we receive a decision in her case.

I review several hundred cases of our paralegals monthly, and such stories are common. No doubt there are individuals on the Social Security rolls who are not in fact entitled to benefits. However, in its haste to remove these few, SSA is routinely trampling on the rights of claimants such as Mrs. Edmonds, my client in Phenix City, Alabama. And it is not uncommon for clients such as her to die while awaiting vindication of their claims. Admittedly Social Security payments are a tremendous cost in the federal budget, but for millions of U. S. citizens, this income is the only income available for our increasingly aging and disabled population.

I would support the creation of a Social Security court to review the administrative decisions of the agency. I am aware of the varying court interpretations of Social Security law; I believe it results from the large federal case docket, and the inability of judges and magistrates to keep current on changes in the law. The disparity in administrative levels of adjudication appears to be more an administrative than judicial problem. Most Administrative Law Judges in our experience are conscientious and careful with the claimants appearing before them; however, due to their heavy workload, they are sometimes unable to develop cases as fully as they might like. With unrepresented claimants, this is a burdensome, complicated, and time-consuming duty, which is often beyond their abilities. Even with represented claimants, the mere writing of a several page well-reasoned decision, including adequate fact development, is difficult. The Offices of Hearings and Appeals are under increasingly heavier burdens now because of the untypically large numbers of cessations coming from the State Disability Determination Units.

On behalf of the Legal Services Corporation of Alabama, I thank you for the opportunity to make the foregoing comments for our clientele and staff. We would be happy to provide further comment at your request.

Respectfully yours,

Marilyn C Newhouse

MARILYN C. NEWHOUSE
Specialist Attorney/
Paralegal Coordinator

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November 3, 1981

Social Security Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Hearings on Social Security Appeals and Case Review Process

Dear Friends:

I am writing to comment on some of the issues which you are considering in your review of the review process in Social Security. I understand that some suggestions have been made to create a Social Security court and also to slacken the standards for administrative law judges to increase the numbers to deal with the backlog.

I strongly oppose weakening the protections for claimants by watering down the requirements for administrative law judges. I also oppose a Social Security Court. Social Security claimants should be given their appeal hearings and reviews with the same dignity and general impartiality accorded to others who have appeals before the Social Security Administration.

The pressure to do this might easily be avoided by one simple procedure. As it stands now, no one in the disability determination unit is required to see the claimant in person. The large number of denials which are overturned on appeal are, in my experience, to a great extent the result of this effort to reduce initial work. At least at the Reconsideration level, the person doing the reconsideration should have a face-to-face meeting with the claimant, wherever possible. The notations by claims workers on the written record are no substitute for the impact of a personal meeting. Certainly there will remain cases which are uncertain after such a meeting, but an enormous number of appealed cases would be satisfactorily resolved at the Reconsideration level if this step were taken. Even for those claimants who are denied at this level, it may very well be true that the opportunity to meet with the decision-maker in person will provide them with the confidence that their claim has been given adequate consideration, and obviate an appeal which otherwise would result in a denial.

Just one note on a different subject. Our organization does not take fees for our work. However, in representing successful claimants, we often receive a note saying that the Social Security Administration is holding out of our client's check 25% of the award, and is waiting to hear whether we would like it. We have objected strenuously to this practice, as it is a reduction of our client's award without foundation. The Social Security Administration should at least resolve the question of what fee, if any, will be taken before the hearing, so as to avoid this unnecessary docking of claimant's benefits.

Thank you very much for the opportunity to comment.

Sincerely,

Nancy Brockway

Nancy Brockway
Chief Attorney

NB:am
cc: Jerry Zeifman, National Senior Citizens Law Center

COMMITTEE ON
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WAYS AND MEANS

TO: House Ways and Means Committee
House Subcommittee on Social Security
Attention: John Selmon
1102 Longworth House Office Building
Washington, D. C. 20515

My name is Steve Ralston and my residence is 4818 Kenmore Avenue, Apt. 202, Alexandria, Virginia 22034. I hold the position of AMSARS Supervisor for the Social Security Administration, Office of Hearings and Appeals, Central Office in Arlington, Virginia. I believe this testimony is pertinent to your hearings regarding the social security appeal and case review process and administrative structures.

Each year several hundred thousands of dollars of public funds are unnecessarily wasted due to 1) lost hearing cassettes or 2) defective hearing cassettes which record the hearings before administrative law judges. Lost or defective hearing cassettes adversely affect the appeals process causing excessive Secretarial Remands (Rehearings) involving court cases. In 1977, AMSARS, Automated Mass Storage and Retrieval System, was proposed for resolving this critical problem. Yet, nearly five years have passed without complete implementation due to classic bureaucratic program mismanagement. This AMSARS program should and can be implemented with cooperation between all OHA components rather than the "turf battles", "non-cooperation", and "decisional paralysis" historically hampering successful implementation. As a result of my initiatives toward improving AMSARS program deficiencies, I was physically locked out of the on-going AMSARS Pilot Program for 120 days. This **CENSORSHIP** was an attempt at stopping the constructive AMSARS program improvements or possible identification of program design problems requiring correction from the AMSARS Supervisor.

This censorship directly conflicts with the AMSARS Supervisors' position description:

1) "The Basic-Function-incumbent has overall responsibility for planning, organizing, directing, and coordinating all activities relative to the total control over the OHA tape cassette inventory,"

2) Major Duties and Responsibilities -

   a) "Analyzes and evaluates complex issues regarding work planning and organization.

   b) "Assists developement of and initiates the policies and procedures for the day to day operations of the section.

   c) "Explores, plans, finds, formulates the most efficient and economical organization of work insuring the highest productivity within the available resources."

The following records comprise The Grievance File supporting the censorship allegations regarding the AMSARS Project for discovering serious program deficiencies:

1) Richard Krodel's hearing testimony before the subcommittee on SSA, Committee on Ways and Means, House of Representatives (1979):

> "Thus AMSARS was proposed by and assigned to me in late 1977, although a similiar project had been proposed and aborted a year earlier."
>
> "About $70,000 was expended for purchase and lease of the main frame equipment by the end of June 1978. From that date to this, no further action has been taken and leasing charges are being incurred at the rate of 5,000 a month."
>
> "I have no authority to take direct action and further am denied access to data which I need for planning purposes." "Finally, I have had experience with three systems projects prior to employment with BHA and in each one it was standard operating procedure to establish a team of experts in impacted functions to coordinate and expedite information and decisions, yet my several requests to do this have been ignored."

2) Memorandum for the Record by Richard Krodel (May 3, 1979):

> "Normally the members of a systems project team are associated as a work group from commencement of planning to end of installation, in varying degrees depending on the expertise required of individual members. Thus each member becomes fully knowledgeable as to the detailed operational aspects of the project and especially as to the impact on the function which each member represents. At all times, all members are consulted on changes or proposed changes and objections resolved by concurrence, or difference reduced to writing and submitted, with pros and cons, for decision."

3) January 7, 1980 Memorandum from James Forbus, Deputy, Associate Commissioner, to RCALJ, San Francisco delaying AMSARS implementation. This premature AMSARS implementation symbolizes the total lack of coordination. Approximately 500 hearing cassettes were received under AMSARS procedures by the operating component without 1) prior notification, 2) computer installation, 3) all equipment/supplies on site in operational readiness, 4) any prior ersonnel training, or 5) adequate staffing.

4) October 15, 1980 Memorandum from the AMSARS Supervisor to the Director, Division of Facilities outlines numerous AMSARS reports submitted, but, unanswered emphasizing the need for a project team and intercomponent cooperation/coordination for a successful AMSARS implementation.

5) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities, 2/13/80, depiting AMSARS problems necessitating correction for a successful implementation, i.e., 1) mail controls, 2) delegation of responsibility, 3) equipment/supplies status, 4) manpower requirements, and 5) training. Only registered mail will provide adequate cassette shipment security preventing unacceptable losses worth approximately $1,300 per hearing. The current DMA AMSARS Pilot Program still presently accepts certified mail despite at least three cassette boxes lost in transit.

6) Memorandum for the Record on 7/15/80 by Richard Krodel again emphasizing the AMSARS Project Team necessity:

> "Reactivating the AMSARS Project Team will expose representatives of impacted functions to deliberations and discussions on the pert schedule, the systems flow charts, and the Tape Cassette Handbook and its appendices, especially on forms, and thus greatly enhance the flow of communication to our peers. In turn, this should improve immensely the probability of sucess for what, again, is preeminently a team project."
>
> "The reference to AMSARS as a "Team Project" can not be overstated. Besides requiring the coordination and cooperation of all personnel involved, AMSARS conceptually is a group effort which involves complex, multiple member interface and interactive relationships. This in turn places a premium on management and decision by exposure and consensus."

7) Memorandum from Dick Krodel to Jim Dolan on 7/29/80:

> "We have requested reactivation of the AMSARS Project Team. This arrangement should provide the means for opening up subjects on which major disagreement is expressed and for assuring full understanding and concurrence or nonconcurrence by consensus."

8) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities, 7/21/80, stopping the ninety minute hearing cassette purchase. The Dictaphone 4000 recording time required to transfer the original hearing data from ninety minute cassettes to one inch master reel tape would increase approximately 13% over the time required by the sixty minute cassettes for an equivalent workload.

9) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities; 8/80, revising/correcting numerous AMSARS procedural discrepancies such as: 1) registered mail utilization rather than certified mail, 2) intra-sectional mail shuttle, 3) subsystem for "defective" or inaudible cassettes, 4) cassette rewinding for recording the entire hearing, 5) cassette retension in the appeals file maintaining the cassette duplication workload within the 4300 machine's output capacity, etc.

> "The language, chronological sequence, inter-relationship, and organizational function of the AMSARS procedures will play a critical factor in the projects' success or failure. Serious miscalculations will result in lost productivety, unpreventable cassette backlogs, subsequent HA-520 processing delays; increased personnel costs, and possibly an increase in Secretarial Remands."

10) Memorandum for the Record by Richard Krodel on September 5, 1980.

> "Over two years ago, I contacted a tech rep from Slye Electronics regarding a proposed evaluation of the then - BHA recording and transcribing system, to include specification of electronic equipment which would help upgrade the system. Nothing came of the contact.

11) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities, 12/8/80, regarding the DMA four track recording system proposal. This DMA proposal recommended purchase of approximately $350,000 worth of field equipment in compatible with the onsite AMSARS equipment since: 1) hearing transfer from four track equipment to two track equipment causes approximately a 5% information loss, 2) since this equipment would only record on one cassette side the actual number of cassettes and storage space would significantly increase, 3) claimants, analysts, transcriptionists, etc., generally do not have access to four track recording equipment, etc.

> "The imcompatible BM 145 recording system will have a significant adverse impact on AMSARS. The dual recording system, 4 track and two track combination, will necessitate additional processing steps inviting lost hearing data, equipment modification, and manpower increases. This four track recording system will probably increase rather than eliminate Secretarial Remands attributed to defective/lost cassettes."

12) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities on 1/2/81 revising the AMSARS cassette identification label. Approximately 300,000 inadequate labels worth several thousands of dollars were apparently discarded. The entire new label revision for 1) accurate cassette identification, 2) adequate computer data entry, 3) correct sorting by decision and sides recorded, and 4) complete and sequential rerecording of all original hearing data.

13) Memorandum from AMSARS Supervisor to Division of Facilities on 2/11/81 regarding nearly $8,390 unnecessary expenditures correcting the original DMA contract order for 100,000 cassette casings.

> "The original 100,000 cassette casings ordered by the Division of Management Analysis did not comply with the AMSARS Program design requirements. This particular casing hinge prevents the identification label's (SSA-2961) adhesion on the lip edge thus inviting loss during transport or handling. Therefore, approximately 31,000 casings presently stored in Room 208, Webb Building, must be exchanged into another casing prior to field distribution."

14) Memorandum from AMSARS Supervisor to the Director, Division of Facilities on 4/6/81 requesting information on the AMSARS Project. No response or information provided thus again depicting uncoopertiveness.

15) Memorandum from the AMSARS Supervisor to the Director, Office of Facilities and Personnel Administration outlining the AMSARS Test and Evaluation Plan (4/7/81). This report established measurable and objective performance standards for AMSARS as criteria for transferring operational responsibility from the Division of Management Analysis to the Division of Facilities. Shortly thereafter, the locks on the AMSARS Rooms 208 and 307, Webb Building were changed preventing access by the AMSARS Supervisor and the Chief, Docket and Files. Yet, other OFPA personnel were granted routine access, i.e., Dan Butler, Greg Romanias, David Mowry, and Lucille Parks. This intential discriminatory censorship was initiated to stop my 1) discovering additional program deficiencies and 2) preventing any interference in the AMSARS operational transfer from OMC to OFPA. The Division of Management Analysis refused to answer or accept these AMSARS performance standards.

16) Memorandum from AMSARS Supervisor to Director, Division of Facilities on March 30, 1981 Concerning AMSARS Transcribers Mofifications Oversight by DMA enabling hearing erasure.

> "The AMSARS Thought Master 260 Transcribers require internal electronic modification concerning several control features to 1) insure audible recording onto the master reel, and 2) prevent "accidental" erasure and total loss of the original hearing data."
>
> "The transcriber's erase key, telephone record switch and the dictate/conference switch should be internally deactivated to prevent "accidental" erasure of the original hearing data. These controls serve no beneficial AMSARS function, but, could prevent a successful operation by causing a large number of Secretarial Remands. Presently a hearing cassette could be erased without detection until

> a duplicate cassette is made. Each cassette improperly erased could possibly cost the agency approximately $1300 per remand."

17) Memorandum from the AMSARS Supervisor to the Director, Office of Facilities and Personnel Administration identifying the totally useless DMA calibration cassette purchase without the necessary voltmeter or decibal meter.

> "The DIN Calibration Cassette or Nortronics Professional Cassette Alignment Tape by itself will not permit alignment of the field cassette recorders' heads. A voltmeter or decibal meter must be used in conjunction with an alignment tape for 1) maintaining recorder head alignment, and 2) determining whether the heads are worn requiring replacement. The instructions for the Nortronics Alignment Tape and other experts specify the use of an amplified A.C. volmeter to measure required decibals. The Division of Management Analysis (DMA) has supplied the ten hearing offices with only DIN Calibration Cassettes."

> "Because the Dictaphone console lights will not indicate whether the entire hearing is audibly rerecorded onto the master reels, the AMSARS operators must actually listen to each hearing during the rerecording process determining whether or not each cassette was audibly rerecorded. Judgemental errors and inaudible cassettes could be significantly reduced by maintaining the correct head alignment and replacing worn heads in the field recorders."

18) Memorandum from EEO complainant to EEO officer on April 29, 1981 refusing a detail to OMC because 1) fear of reprisal for thousands of dollars worth of AMSARS program deficiencies by DMA, 2) the derogatory informational appraisal given Robert Weinaug from DMA, and 3) fear of reprisal for representing Robert Weinaug in an EEO complaint against the Director, DMA, Clarence Wheeler. Additionally as the AMSARS Supervisor, a detail to my own office was totally unjustified.

> "On April 29, 1981 I was notified a 120 day detail maybe forthcoming. Under no circumstances do I want any detail particularly to the Division of Management Analysis. This detail has no legitimate basis; but, rather constitutes a REPRISAL action by Mr. Clarence Wheeler and Mr. Orlando McGruder for 1) representing Mr. Robert Weinaug in an EEO complaint and 2) my personally filing an EEO complaint. The Division of Management Analysis should be responsible and accountable for the AMSARS project until objective performance standards are accomplished."

19) Memorandum from AMSARS Supervisor to Director, Office of Facilities and Personnel Administration on May 15, 1981 identifying DMA oversight for field instructions leaving cassettes "knockouts" intact. This oversight could endanger the large monetary savings for recycling cassettes requiring unnecessary yearly cassette purchases.

> "Tape cassettes have a built in record-prevent device, a

> tab or "knock-out", for permanently storing information. There is an interlock in recorders which prevents recording on the cassette when the tab or "knock-out" has been activated. Many hearing offices routinely push out the tabs (Knock-outs) on the cassettes' lip edge after the hearing avoiding accidental erasure. However, under AMSARS the original hearing data will be preserved permanently on the master reels rather than 60 minute cassettes. This record-prevent device can be defeated by covering the knock-out holes with adhesive tape."
>
> "Ideally, the recycled cassettes should be ready for recording without taping over the tabs (Knock-outs). Field instructions should be prepared by the Division of Management Analysis requesting the tabs (Knock-outs) on the cassettes lip edge be left intact. Otherwise, the entire recycling process could be severely hampered requiring large yearly cassette purchases. I do not recommend recycling any cassettes with the tabs (Knock-outs) pushed in."

20) Memorandum from the AMSARS Supervisor to the Director, Policy and Procedures on May 26, 1981 depicting payment for AMSARS file material. This emphasizes the DMA censorship preventing access to data for performing official duties. The AMSARS Pilot Program represents an elaborate coverup by DMA.

> "Per your May 22, 1981 memorandum, please find enclosed a check for $68.60 covering xeroxing charges concerning AMSARS file material."

21) Memorandum from the AMSARS Supervisor to the Director, Division of Facilities on May 26, 1981 identifying AMSARS procedural discrepancies by the field. Approximately 7% of all cassettes received by the AMSARS Pilot Program did not comply with procedures absolutely critical for a successful AMSARS implementation. The DMA repeatedly refused to correct this problem through an extensive correspondence feedback program.

> "On May 26, 1981, the Cassette Library received 13 hearing cassettes from Mobile, Alabama. Eight hearing cassettes should have been processed in accordance with AMSARS procedures. A review depicted numerous procedural discrepancies such as:
>
> 1) No identification of total sides recorded on the cassette label, SSA-2961; for three cassettes;
> 2) Improper placement of identification label, SSA-2961, on all casings;
> 3) AMSARS shipping lists, SSA-2966 were not utilized;
> 4) First class registered mail service was not utilized;

> 5) Handwritten information was placed on the green cassette label on one case.
>
> The AMSARS Pilot Program must quickly identify and correct problems for a successful AMSARS implementation. The above procedural discrepancies will have a severe adverse impact on AMSARS if not corrected. I suggest DMA prepare supplemental correspondence for the Mobile, Alabama, hearing office correcting these problems. Eventually, a form letter should be developed from the Pilot Program's experiences for the feedback correspondence program."

22) Form 393 and memorandum from Robert Weinaug to the record identifying approximately $22,000 worth of unnecessary AMSARS equipment expenditures by the Division of Management Analysis.

> "In our discussion, we could not understand why two multiline amp sets had been purchased for the reproducer in Room 208. Since three more reproducers were on order, I obtained the Form 393 from Chester Kuchno. While examining this document, certain mistakes were noted. All prices were incorrect. Three rack consoles for reproducer, which holds the electronic equipment, had not been ordered. Six multi-line amps sets had been ordered and should not have been. This option allows information to be taken from 39 channels simultaneously. Since we will only retrieve information from a single channel at one time these options at a cost of $12,000 are a totally unnecessary and useless luxury."

23) Memorandum from the AMSARS Supervisor to Director, Policy and Procedures (FOIA) on June 27, 1981 requesting additional AMSARS information withheld by the Division of Management Analysis.

24) Memorandum from the AMSARS Supervisor to the Director, Office of Facilities and Personnel Administration on July 2, 1981 extending the DMA cassette retention span from four months to six months to 1) meet the dictaphone 4300's output capacity, 2) expedite processing times reducing labor costs, 3) prevent the necessity for a night shift, and 4) provide the highest quality recording possible for OHA components. Once again, the July 16, 1981 DMA memorandum indicates total disregard for constructive suggestions from the operating component.

> "All AMSARS hearing cassettes should be retained for a six month retention span. Current procedures retain the unfavorable/partially favorable decisions four months and the favorable decisions six months. A six month retention span will significantly reduce the number of cassettes duplicated from the archival reel tape."
>
> "The present four month retention span will still require excessive duplication from reel tape exceeding the Dictaphone 4300's output capacity. With maximum machine time and manpower utilization, the Dictaphone 4300 can only duplicate approximately 560 cassettes per month. This

> output capacity will not meet anticipated workload projections without a night shift for cassette duplication. However, a six month retention span will significantly reduce the duplication requirements without adversely affecting the overall system."
>
> "Furthermore, the original cassette should be retrieved as often as possible since the duplication process actually reduces the recordings' quality. Retrieval from the reel tape represents a one to one ratio identical to the original hearing length. Thus, a sixty minute hearing will require sixty minutes for duplication with subsequent additional labor costs and processing delays. Original cassette retrieval is much more economical than the duplication process while providing a better recording."

25) Memorandum from the AMSARS Supervisor to the Director, Office of Facilities and Personnel Administration on July 13, 1981 providing a vital form letter in accordance with the AMSARS procedural handbook. Despite previous DMA coordination and concurrence with this procedure, this correspondence feedback letter identifying field discrepancies requiring correction was rejected by DMA. The Director, Division of Facilities stated:

> "Due to the volume of cassette labeling deficiencies coming from the hearing offices, a suggested form letter has been developed. The form letter will provide the eventual AMSARS Operators a quick and easy method of notifying the hearing offices of their deficiencies. The development of the form letter has already been provided for in accordance with the Tape Cassette Handbook, Section V, Central Office Input, Subsection A, Set-Up Operation, Sub-part 4:
>
> > "Complete and mail the form letter regarding procedural discrepancies or missing cassettes if any for the hearing office correction and feedback."
>
> "I would appreciate it if you would have your staff review the form and if it is satisfactory with you, implement its usage. I believe this is a viable tool, and necessary, and it should be construed as merely a suggestion, rather than any turf battle."

26) Memorandum from the Director, Office of Management Coordination to the Director, Office of Facilities and Personnel Administration on July 16, 1981 displaying the total lack of coordination and cooperation on AMSARS permitting DMA self-evaluation without outside critique.

> "During the period in which the pilot test of the system is being conducted, DMA has the primary responsibility for ALL AMSARS activities. This means that although an AMSARS section will be officially established in D&F, it must play an inactive role in the automated operations of AMSARS until the pilot test has been satisfactorily concluded."

27) Memorandum from the Director, Division of Management Analysis to the Director, Division of Facilities on July 30, 1981 in response to the April 7, 1981 memorandum outlining the AMSARS test and evaluation plan emphasizes again OMA's refusal to cooperate on AMSARS:

> "We agreed that, given the reasonable expectations of answers furthcoming, as outlined above, no formal response would be submitted to you (or anyone else) until a more appropriate stage in the life of the AMSARS project. I see no reason to change our thinking on that at this time."

The AMSARS Pilot Program had been operational for three months at the time of this memorandum. Furthermore, the above statement conflicts directly with the Deputy Associate Commissioners' September 8, 1981 memorandum:

> "Item 3-I have been advised that the Director, Division of Management Analysis did reply to the Director, Division of Facilities regarding the April 7, 1981 memorandum."

I am not aware of any such response by DMA.

I hope you find this information beneficial. I do not believe the new OHA administration with Louis B. Hayes' leadership will permit another grossly mismanaged project like AMSARS. The Associate Commissioner's November 2, 1981 Memorandum specifically states:

> "The third major challenge is to improve the management practices and techniques throughout OHA. The number of complaints, grievances, and requests for investigations is cause for serious concern and suggests the need for increased attention to the way management works with employees. We must identify the underlying causes of the problems, and then apply the solutions that will assure OHA's image and credibility as a fully professional and well managed organization...
>
> "Most importantly, we must foster an attitude among all employees and supervisors that everyone has a contribution towards both understanding and solving the problems we face. I hope that all employees will feel free to volunteer their ideas and recommendations for improving the way we do business, and that supervisors at all levels will encourage creativity on the part of their employees and will be receptive to their ideas for improvement."

This initiative alone with strong continuous support from upper management could create a work environment conducive to high productivity, high morale, and program efficiency necessary for meeting the challenges ahead.

Sincerely,

Steve Ralston

Steve Ralston